

111TH CONGRESS  
1ST SESSION

# H. R. 3090

To improve the health of minority individuals, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mrs. CHRISTENSEN (for herself, Mr. DAVIS of Illinois, Ms. BORDALLO, Ms. ROYBAL-ALLARD, Mr. CLYBURN, Mr. RANGEL, Ms. LEE of California, Mr. HONDA, Mr. CUMMINGS, Ms. JACKSON-LEE of Texas, Ms. CLARKE, Mr. WATT, Mr. CLAY, Mr. THOMPSON of Mississippi, Mr. MEEK of Florida, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. AL GREEN of Texas, Mr. JOHNSON of Georgia, Mr. CLEAVER, Mr. ELLISON, Ms. WATSON, Mr. JACKSON of Illinois, Mr. CARSON of Indiana, Mr. TOWNS, Ms. FUDGE, Ms. KILPATRICK of Michigan, Ms. RICHARDSON, Ms. BALDWIN, Mr. FATTAH, Mr. BISHOP of Georgia, Mr. SCOTT of Georgia, Mr. PAYNE, Mr. MEEKS of New York, Mr. GRIJALVA, Mr. SCOTT of Virginia, Mr. DAVIS of Alabama, Mr. GRAYSON, Ms. EDWARDS of Maryland, Ms. MOORE of Wisconsin, Ms. CORRINE BROWN of Florida, Ms. WATERS, Ms. HIRONO, Ms. DEGETTE, Mr. FALEOMAVAEGA, Ms. MATSUI, Mr. LEWIS of Georgia, Mr. GONZALEZ, Mr. SABLAN, Mr. PIERLUISI, Mr. REYES, Mr. ORTIZ, Ms. VELÁZQUEZ, Mr. LUJÁN, Mr. HASTINGS of Florida, and Mr. CUELLAR) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, the Judiciary, Natural Resources, Armed Services, Veterans' Affairs, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To improve the health of minority individuals, and for other purposes.

1        *Be it enacted by the Senate and House of Representa-*  
 2        *tives of the United States of America in Congress assembled,*

3        **SECTION 1. SHORT TITLE.**

4        This Act may be cited as the “Health Equity and  
 5        Accountability Act of 2009”.

6        **SEC. 2. TABLE OF CONTENTS.**

7        The table of contents of this Act is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

TITLE I—CULTURALLY AND LINGUISTICALLY APPROPRIATE  
HEALTH CARE

Sec. 101. Amendment to the Public Health Service Act.

Sec. 102. Federal reimbursement for culturally and linguistically appropriate  
services under the Medicare, Medicaid and the State Children’s  
Health Insurance Program.

Sec. 103. Increasing understanding of and improving health literacy.

Sec. 104. Assurances for receiving Federal funds.

Sec. 105. Report on Federal efforts to provide culturally and linguistically ap-  
propriate health care services.

Sec. 106. English for speakers of other languages.

Sec. 107. Definition.

Sec. 108. Treatment of the Medicare part B program under title VI of the Civil  
Rights Act of 1964.

Sec. 109. Implementation.

TITLE II—HEALTH WORKFORCE DIVERSITY

Sec. 201. Amendment to the Public Health Service Act.

Sec. 202. Health Careers Opportunity Program.

Sec. 203. Program of excellence in health professions education for underrep-  
resented minorities.

Sec. 204. Hispanic-Serving Health Professions Schools.

Sec. 205. Health professions student loan fund; authorizations of appropri-  
ations regarding students from disadvantaged backgrounds.

Sec. 206. National Health Service Corps; recruitment and fellowships for indi-  
viduals from disadvantaged backgrounds.

Sec. 207. Loan repayment program of Centers for Disease Control and Preven-  
tion.

Sec. 208. Cooperative agreements for online degree programs at schools of pub-  
lic health and schools of allied health.

Sec. 209. Mid-care health professions scholarship program.

Sec. 210. National report on the preparedness of health professionals to care  
for diverse populations.

Sec. 211. Scholarship and fellowship programs.

Sec. 212. Advisory Committee on Health Professions Training for Diversity.

Sec. 213. McNair Postbaccalaureate Achievement Program.

## TITLE III—DATA COLLECTION AND REPORTING

- Sec. 301. Amendment to the Public Health Service Act.
- Sec. 302. Collection of race and ethnicity data by the Social Security Administration.
- Sec. 303. Revision of HIPAA claims standards.
- Sec. 304. National Center for Health Statistics.
- Sec. 305. Geo-access study.
- Sec. 306. Racial, ethnic, and linguistic data collected by the Federal Government.
- Sec. 307. Health information technology grants.
- Sec. 308. Study of health information technology in medically underserved communities.
- Sec. 309. Health information technology in medically underserved communities.
- Sec. 310. Data collection and analysis grants to minority-serving institutions.
- Sec. 311. Health information technology grants for rural health care providers.
- Sec. 312. Survey questions on sexual orientation and gender identity.
- Sec. 313. Disaggregation of comparative effectiveness research data.

## TITLE IV—ACCOUNTABILITY AND EVALUATION

## Subtitle A—General Provisions

- Sec. 401. Federal agency plan to eliminate disparities and improve the health of minority populations.
- Sec. 402. Prohibition on discrimination in Federal assisted health care services and research programs on the basis of sex, race, color, national origin, sexual orientation, gender identity, or disability status.
- Sec. 403. Accountability within the Department of Health and Human Services.
- Sec. 404. Office of Minority Health.
- Sec. 405. Establishment of the Indian Health Service as an agency of the Public Health Service.
- Sec. 406. Establishment of individual offices of minority health within agencies of the Public Health Service.
- Sec. 407. Office of Minority Health at the Centers for Medicare & Medicaid Services.
- Sec. 408. Office of Minority Affairs at the Food and Drug Administration.
- Sec. 409. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 410. United States Commission on Civil Rights.
- Sec. 411. Sense of Congress concerning full funding of activities to eliminate racial and ethnic health disparities.
- Sec. 412. Guidelines for disease screening for minority patients.
- Sec. 413. National Institute for Minority Health and Health Disparities.
- Sec. 414. IOM report on LGBT health disparities.

## Subtitle B—Improving Environmental Justice

- Sec. 421. Codification of Executive Order 12898.
- Sec. 422. Implementation of recommendations by Environmental Protection Agency.
- Sec. 423. Grant program.
- Sec. 424. Additional research on the relationship between the built environment and the health of community residents.

## TITLE V—IMPROVEMENT OF HEALTH CARE SERVICES

### Subtitle A—Health Empowerment Zones

- Sec. 501. Short title.
- Sec. 502. Findings.
- Sec. 503. Designation of health empowerment zones.
- Sec. 504. Assistance to those seeking designation.
- Sec. 505. Benefits of designation.
- Sec. 506. Definition.
- Sec. 507. Authorization of appropriations.

### Subtitle B—Other Improvements of Health Care Services

#### CHAPTER 1—IN GENERAL

- Sec. 511. Amendment to the Public Health Service Act.
- Sec. 512. Medicaid payment for certain aliens.
- Sec. 513. Medicaid payment parity for the territories.
- Sec. 514. Extension of Medicare secondary payer.
- Sec. 515. Border health grants.
- Sec. 516. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 517. Grants to promote positive health behaviors in women and children.
- Sec. 518. Exception for citizens of freely associated States.
- Sec. 519. Medicare graduate medical education.
- Sec. 520. HIV/AIDS reduction in racial and ethnic minority communities.
- Sec. 521. Grants for racial and ethnic approaches to community health.
- Sec. 522. Critical access hospital improvements.
- Sec. 523. Coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program.
- Sec. 524. Establishment of rural community hospital (RCH) program.
- Sec. 525. Medicare remote monitoring pilot projects.
- Sec. 526. Rural health quality advisory commission and demonstration projects.
- Sec. 527. Rural health care services.
- Sec. 528. Community health center collaborative access expansion.
- Sec. 529. Facilitating the provision of telehealth services across State lines.
- Sec. 530. Removing barriers to health care and nutrition assistance health coverage for children, pregnant women, and lawfully residing individuals.
- Sec. 531. Removing Medicare barrier to health care.

#### CHAPTER 2—LUNG CANCER MORTALITY REDUCTION

- Sec. 541. Short title.
- Sec. 542. Findings.
- Sec. 543. Sense of Congress concerning investment in lung cancer research.
- Sec. 544. Lung Cancer Mortality Reduction Program.
- Sec. 545. Department of defense and the department of veterans affairs.
- Sec. 546. Lung cancer advisory board.
- Sec. 547. Authorization of appropriations.

### TITLE VI—ELIMINATING DISPARITIES IN DIABETES PREVENTION ACCESS AND CARE ACT

#### Subtitle A—NATIONAL INSTITUTES OF HEALTH

- Sec. 611. Research, treatment, and education.

Subtitle B—CENTERS FOR DISEASE CONTROL AND PREVENTION

Sec. 621. Research, education, and other activities.

Subtitle C—HEALTH RESOURCES AND SERVICES ADMINISTRATION

Sec. 631. Research, education, and other activities.

Subtitle D—ADDITIONAL PROGRAMS

Sec. 641. Research, education, and other activities.

# 1 **TITLE I—CULTURALLY AND LIN-** 2 **GUISTICALLY APPROPRIATE** 3 **HEALTH CARE**

## 4 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

### 5 **ACT.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Effective communication is essential to  
8 meaningful access to quality physical and mental  
9 health care.

10 (2) Research establishes that the lack of lan-  
11 guage services creates barriers to and diminishes the  
12 quality of health care and health status for limited  
13 English proficient individuals.

14 (3) The number of limited English speaking  
15 residents in the United States who speak English  
16 less than very well and, therefore, cannot effectively  
17 communicate with health and social service providers  
18 continues to increase significantly.

19 (4) The responsibility to fund language services  
20 in the provision of health care and health care-re-  
21 lated services to limited English proficient individ-

1 uals is a societal one that cannot fairly be visited  
2 solely upon the health care, public health or social  
3 services community.

4 (5) Linguistic diversity in the health care and  
5 health care-related services workforce is important  
6 for providing all patients the environment most con-  
7 ducive to positive health outcomes.

8 (6) All members of the health care and health  
9 care-related services community should continue to  
10 educate their staff and constituents about limited  
11 English proficient issues and help them identify re-  
12 sources to improve access to quality care for limited  
13 English proficient individuals.

14 (7) Access to English as a Second Language in-  
15 struction is an important mechanism for ensuring  
16 effective communication and eliminating the lan-  
17 guage barriers that impede access to health care.

18 (8) Competent languages services in health care  
19 settings should be available as a matter of course.

20 (b) AMENDMENT.—The Public Health Service Act  
21 (42 U.S.C. 201 et seq.) is amended by adding at the end  
22 the following:

1 **“TITLE XXXI—CULTURALLY AND**  
2 **LINGUISTICALLY APPRO-**  
3 **PRIATE HEALTH CARE**

4 **“SEC. 3100. DEFINITIONS.**

5 “In this title:

6 “(1) BILINGUAL.—The term ‘bilingual’ with re-  
7 spect to an individual means a person who has suffi-  
8 cient degree of proficiency in two languages.

9 “(2) COMPETENT INTERPRETER SERVICES.—  
10 The term ‘competent interpreter services’ means a  
11 trans-language rendition of a spoken message in  
12 which the interpreter comprehends the source lan-  
13 guage and can speak comprehensively in the target  
14 language to convey the meaning intended in the  
15 source language. The interpreter knows health and  
16 health-related terminology and provides accurate in-  
17 terpretations by choosing equivalent expressions that  
18 convey the best matching and meaning to the source  
19 language and captures, to the greatest possible ex-  
20 tent, all nuances intended in the source message.

21 “(3) COMPETENT TRANSLATION SERVICES.—  
22 The term ‘competent translation services’ means a  
23 trans-language rendition of a written document in  
24 which the translator comprehends the source lan-  
25 guage and can write comprehensively in the target

1 language to convey the meaning intended in the  
2 source language. The translator knows health and  
3 health-related terminology and provides accurate  
4 translations by choosing equivalent expressions that  
5 convey the best matching and meaning to the source  
6 language and captures, to the greatest possible ex-  
7 tent, all nuances intended in the source document.

8 “(4) EFFECTIVE COMMUNICATION.—The term  
9 ‘effective communication’ means an exchange of in-  
10 formation between the provider of health care or  
11 health care-related services and the limited English  
12 proficient recipient of such services that enables lim-  
13 ited English proficient individuals to access, under-  
14 stand, and benefit from health care or health care-  
15 related services.

16 “(5) GRIEVANCE RESOLUTION PROCESS.—The  
17 term ‘grievance resolution process’ means all aspects  
18 of dispute resolution including filing complaints,  
19 grievance and appeal procedures and court action.

20 “(6) HEALTH CARE GROUP.—The term ‘health  
21 care group’ means a group of physicians organized,  
22 at least in part, for the purposes of providing physi-  
23 cians’ services under the Medicaid, SCHIP, or Medi-  
24 care programs and may include a hospital and any  
25 other individual or entity furnishing services covered



1 under the Medicaid, SCHIP or Medicare programs  
2 that is affiliated with the health care group.

3 “(7) HEALTH CARE SERVICES.—The term  
4 ‘health care services’ means services that address  
5 physical as well as mental health conditions in all  
6 care settings.

7 “(8) HEALTH CARE-RELATED SERVICES.—The  
8 term ‘health care-related services’ means human or  
9 social services programs or activities that provide ac-  
10 cess, referrals or links to health care.

11 “(9) INDIAN TRIBE.—The term ‘Indian tribe’  
12 means any Indian tribe, band, nation, or other orga-  
13 nized group or community, including any Alaska Na-  
14 tive village or group or regional or village corpora-  
15 tion as defined in or established pursuant to the  
16 Alaska Native Claims Settlement Act (85 Stat. 688)  
17 (43 U.S.C. 1601 et seq.), which is recognized as eli-  
18 gible for the special programs and services provided  
19 by the United States to Indians because of their sta-  
20 tus as Indians.

21 “(10) INTEGRATED HEALTH CARE DELIVERY  
22 SYSTEM.—The term ‘integrated health care delivery  
23 system’ means a system comprised of more than one  
24 type of health care provider for the purposes of pro-  
25 viding a. The providers may include hospitals, clin-

1        ics, home health agencies, ambulatory surgery cen-  
2        ters, skilled nursing facilities, rehabilitation facilities  
3        and clinics, and employed, independent or contracted  
4        physicians.

5            “(11) INTERPRETING/INTERPRETATION.—The  
6        terms ‘interpreting’ and ‘interpretation’ mean the  
7        transmission of a spoken message from one language  
8        into another, faithfully, accurately, and objectively.

9            “(12) LANGUAGE ACCESS.—The term ‘language  
10       access’ means the provision of language services to  
11       an LEP individual designed to enhance that individ-  
12       ual’s access to, understanding of or benefit from  
13       health care or health care-related services.

14           “(13) LANGUAGE SERVICES.—The term ‘lan-  
15       guage services’ means provision of healthcare serv-  
16       ices directly in a non-English language, interpreta-  
17       tion, translation and non-English signage.

18           “(14) LEP.—The term ‘LEP’ means limited  
19       English proficient.

20           “(15) LEP RELATED DATA COLLECTION AC-  
21       TIVITIES.—The term ‘LEP related data collection  
22       activities’ includes identifying, collecting, storing,  
23       tracking, and analyzing primary language data, and  
24       information on the methods used to meet the lan-

1        guage access needs of limited English proficient in-  
2        dividuals.

3            “(16) MEDICARE, MEDICAID, AND SCHIP.—The  
4        terms ‘Medicare’, ‘Medicaid’, and ‘SCHIP’ means  
5        the respective programs under titles XVIII, XIX,  
6        and XXI of the Social Security Act.

7            “(17) MINORITY.—

8            “(A) IN GENERAL.—The terms ‘minority’  
9        and ‘minorities’ refer to individuals from a mi-  
10       nority group.

11           “(B) POPULATIONS.—The term ‘minority’,  
12        with respect to populations, refers to racial and  
13        ethnic minority groups.

14           “(18) MINORITY GROUP.—The term ‘minority  
15        group’ has the meaning given the term ‘racial and  
16        ethnic minority group’.

17           “(19) RACIAL AND ETHNIC MINORITY GROUP.—  
18        The term ‘racial and ethnic minority group’ means  
19        American Indians and Alaska Natives, African  
20        Americans (including Caribbean Blacks, Africans  
21        and other Blacks), Asian Americans, Hispanics (in-  
22        cluding Latinos), and Native Hawaiians and other  
23        Pacific Islanders.

24           “(20) ON-SITE INTERPRETING/INTERPRETA-  
25        TION.—The term ‘on-site interpreting/interpretation’

1 means a method of interpreting/interpretation for  
2 which the interpreter is in the physical presence of  
3 the provider of health care or health care-related  
4 services and the limited English proficient recipient  
5 of such services.

6 “(21) SECRETARY.—The term ‘Secretary’  
7 means the Secretary of Health and Human Services.

8 “(22) SIGHT TRANSLATION.—The term ‘sight  
9 translation’ means the transmission of a written  
10 message in one language into a spoken message in  
11 another language.

12 “(23) STATE.—The term ‘State’ means each of  
13 the several states, the District of Columbia, the  
14 Commonwealth of Puerto Rico, the Indian tribes,  
15 the U.S. Virgin Islands, Guam, American Samoa,  
16 and the Commonwealth of the Northern Mariana Is-  
17 lands.

18 “(24) TELEPHONIC INTERPRETATION.—The  
19 term ‘telephonic interpretation’ (also known as over  
20 the phone interpretation or OPI) means a method of  
21 interpreting/interpretation for which the interpreter  
22 is not in the physical presence of the provider of  
23 health care or related services and the limited  
24 English proficient recipient of such services but is  
25 connected via telephone.

1           “(25) TRANSLATION.—The term ‘translation’  
2 means the transmission of a written message in one  
3 language into a written message in another lan-  
4 guage.

5           “(26) VIDEO INTERPRETATION.—The term  
6 ‘video interpretation’ means a method of inter-  
7 preting/interpretation for which the interpreter is  
8 not in the physical presence of the provider of health  
9 care or related services and the limited English pro-  
10 ficient recipient of such services but is connected via  
11 a video hook-up that includes both audio and video  
12 transmission.

13           “(27) VITAL DOCUMENT.—The term ‘vital doc-  
14 ument’ includes but is not limited to applications for  
15 government programs that provide health care serv-  
16 ices; medical or financial consent forms; financial as-  
17 sistance documents, letters containing important in-  
18 formation regarding patient instructions (e.g., pre-  
19 scriptions, referrals to other providers, discharge  
20 plans) and participation in a program (such as a  
21 Medicaid managed care program); notices pertaining  
22 to the reduction, denial or termination of services or  
23 benefits; notices of the right to appeal such actions;  
24 and notices advising limited English proficient indi-

1       viduals of the availability of free language services,  
2       and other outreach materials.

3       **“SEC. 3101. IMPROVING ACCESS TO SERVICES FOR INDIVID-**  
4                   **UALS WITH LIMITED ENGLISH PROFICIENCY.**

5       “(a) PURPOSE.—As provided in Executive Order  
6       13166, it is the purpose of this section—

7               “(1) to improve Federal agency performance re-  
8       garding access to federally conducted and federally  
9       assisted programs and activities for individuals who  
10      are limited in their English proficiency;

11              “(2) to require each Federal agency to examine  
12      the services it provides and develop and implement  
13      a system by which limited English proficient individ-  
14      uals can obtain meaningful access to those services  
15      consistent with, and without substantially burdening,  
16      the fundamental mission of the agency;

17              “(3) to require each Federal agency to ensure  
18      that recipients of Federal financial assistance pro-  
19      vide meaningful access to their limited English pro-  
20      ficient applicants and beneficiaries;

21              “(4) to ensure that recipients of Federal finan-  
22      cial assistance take reasonable steps, consistent with  
23      the guidelines set forth in the Limited English Pro-  
24      ficient Guidance of the Department of Justice (as  
25      issued on June 12, 2002), to ensure meaningful ac-

1       cess to their programs and activities by limited  
2       English proficient individuals; and

3               “(5) to ensure compliance with title VI of the  
4       Civil Rights Act of 1964 and that health care pro-  
5       viders and organizations do not discriminate in the  
6       provision of services.

7       “(b) FEDERALLY CONDUCTED PROGRAMS AND AC-  
8       TIVITIES.—

9               “(1) IN GENERAL.—Not later than 120 days  
10       after the date of enactment of this title, each Fed-  
11       eral agency that carries out health care-related ac-  
12       tivities shall prepare a plan to improve access to the  
13       federally conducted health care-related programs  
14       and activities of the agency by limited English pro-  
15       ficient individuals. Each Federal agency must ensure  
16       that such plan is fully implemented not later than  
17       one year after the date of enactment of this Act.

18              “(2) PLAN REQUIREMENT.—Each plan under  
19       paragraph (1) shall include—

20               “(A) the steps the agency will take to en-  
21       sure that limited English proficient individuals  
22       have access to the agency’s federally conducted  
23       health care and health care-related programs  
24       and activities;

1           “(B) the policies and procedures for identi-  
2           fying, assessing, and meeting the language  
3           needs of its limited English proficient bene-  
4           ficiaries served by federally conducted programs  
5           and activities;

6           “(C) the steps the agency will take for its  
7           federally conducted programs and activities to  
8           provide a range of language assistance options,  
9           notice to limited English proficient individuals  
10          of the right to competent language services,  
11          periodic training of staff, monitoring and qual-  
12          ity assessment of the language services and, in  
13          appropriate circumstances, the translation of  
14          written materials;

15          “(D) the steps the agency will take to en-  
16          sure that applications, forms, and other rel-  
17          evant documents for its federally conducted pro-  
18          grams and activities are competently translated  
19          into the primary language of a limited English  
20          proficient client where such materials are need-  
21          ed to improve access to federally conducted and  
22          federally assisted programs and activities for  
23          such a limited English proficient individual; and

24          “(E) the resources the agency will provide  
25          to assist recipients of Federal funds to improve



1 access to health care or health care related pro-  
2 grams and activities for limited English pro-  
3 ficient individuals.

4 Each agency shall send a copy of such plan to the  
5 Department of Justice, which shall serve as the cen-  
6 tral repository of the agencies' plans.

7 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-  
8 TIES.—

9 “(1) IN GENERAL.—Not later than 120 days  
10 after the date of enactment of this title, each Fed-  
11 eral agency providing health care-related Federal fi-  
12 nancial assistance shall ensure that the guidance for  
13 recipients of Federal financial assistance developed  
14 by the agency to ensure compliance with title VI of  
15 the Civil Rights Act of 1964 (42 U.S.C. 2000d et  
16 seq.) is specifically tailored to the recipients of such  
17 assistance. Each agency shall send a copy of such  
18 guidance to the Department of Justice which shall  
19 serve as the central repository of the agencies' plans.  
20 After approval by the Department of Justice, each  
21 agency shall publish its guidance document in the  
22 Federal Register for public comment.

23 “(2) REQUIREMENTS.—The agency-specific  
24 guidance developed under paragraph (1) shall take  
25 into account the types of health care services pro-

1 vided by the recipients, the individuals served by the  
2 recipients, and other factors set out in such stand-  
3 ards.

4 “(3) EXISTING GUIDANCES.—A Federal agency  
5 that has developed a guidance for purposes of title  
6 VI of the Civil Rights Act of 1964 shall examine  
7 such existing guidance, as well as the programs and  
8 activities to which such guidance applies, to deter-  
9 mine if modification of such guidance is necessary to  
10 comply with this subsection.

11 “(4) CONSULTATION.—Each Federal agency  
12 shall consult with the Department of Justice in es-  
13 tablishing the guidances under this subsection.

14 “(d) CONSULTATIONS.—

15 “(1) IN GENERAL.—In carrying out this sec-  
16 tion, each Federal agency that carries out health  
17 care and health care-related activities shall ensure  
18 that stakeholders, such as limited English proficient  
19 individuals and their representative organizations,  
20 recipients of Federal assistance, and other appro-  
21 priate individuals or entities, have an adequate op-  
22 portunity to provide input with respect to the actions  
23 of the agency.

24 “(2) EVALUATION.—Each Federal agency de-  
25 scribed in paragraph (1) shall evaluate the—

1           “(A) particular needs of the limited  
2           English proficient individuals served by the  
3           agency;

4           “(B) particular needs of the limited  
5           English proficient individuals served by the  
6           agency’s recipients of Federal financial assist-  
7           ance; and

8           “(C) burdens of compliance with the agen-  
9           cy guidance and this section for the agency and  
10          its recipients.

11   **“SEC. 3102. NATIONAL STANDARDS FOR CULTURALLY AND**  
12                   **LINGUISTICALLY APPROPRIATE SERVICES IN**  
13                   **HEALTH CARE.**

14          “Recipients of Federal financial assistance from the  
15   Secretary shall, to the extent reasonable and practicable  
16   after applying the 4-factor analysis described in title V  
17   of the Guidance to Federal Financial Assistance Recipi-  
18   ents Regarding Title VI Prohibition Against National Ori-  
19   gin Discrimination Affecting Limited-English Proficient  
20   Persons (June 12, 2002)—

21           “(1) implement strategies to recruit, retain, and  
22          promote individuals at all levels of the organization  
23          to maintain a diverse staff and leadership that can  
24          provide culturally and linguistically appropriate

1 health care to patient populations of the service area  
2 of the organization;

3 “(2) ensure that staff at all levels and across all  
4 disciplines of the organization receive ongoing edu-  
5 cation and training in culturally and linguistically  
6 appropriate service delivery;

7 “(3) offer and provide language assistance serv-  
8 ices, including trained bilingual staff and interpreter  
9 services, at no cost to each patient with limited  
10 English proficiency at all points of contact, in a  
11 timely manner during all hours of operation;

12 “(4) notify patients of their right to receive lan-  
13 guage assistance services in their primary language;

14 “(5) ensure the competence of language assist-  
15 ance provided to limited English proficient patients  
16 by interpreters and bilingual staff, and ensure that  
17 family, particularly minor children, and friends are  
18 not used to provide interpretation services—

19 “(A) except in case of emergency; or

20 “(B) except on request of the patient, who  
21 has been informed in his or her preferred lan-  
22 guage of the availability of free interpretation  
23 services;

24 “(6) make available easily understood patient-  
25 related materials, if such materials exist for non-lim-

1       ited English proficient patients, including informa-  
2       tion or notices about termination of benefits and  
3       post signage in the languages of the commonly en-  
4       countered groups or groups represented in the serv-  
5       ice area of the organization;

6               “(7) develop and implement clear goals, poli-  
7       cies, operational plans, and management account-  
8       ability and oversight mechanisms to provide cul-  
9       turally and linguistically appropriate services;

10              “(8) conduct initial and ongoing organizational  
11       assessments of culturally and linguistically appro-  
12       priate services-related activities and integrate valid  
13       linguistic competence-related measures into the in-  
14       ternal audits, performance improvement programs,  
15       patient satisfaction assessments, and outcomes-based  
16       evaluations of the organization;

17              “(9) ensure that, consistent with the privacy  
18       protections provided for under the regulations pro-  
19       mulgated under section 264(c) of the Health Insur-  
20       ance Portability and Accountability Act of 1996 (42  
21       U.S.C. 1320d–2 note)—

22                   “(A) data on the individual patient’s race,  
23       ethnicity, and primary language are collected in  
24       health records, integrated into the organiza-

1           tion’s management information systems, and  
2           periodically updated; and

3           “(B) if the patient is a minor or is inca-  
4           pacitated, the primary language of the parent  
5           or legal guardian is collected;

6           “(10) maintain a current demographic, cultural,  
7           and epidemiological profile of the community as well  
8           as a needs assessment to accurately plan for and im-  
9           plement services that respond to the cultural and  
10          linguistic characteristics of the service area of the  
11          organization;

12          “(11) develop participatory, collaborative part-  
13          nerships with communities and utilize a variety of  
14          formal and informal mechanisms to facilitate com-  
15          munity and patient involvement in designing and im-  
16          plementing culturally and linguistically appropriate  
17          services-related activities;

18          “(12) ensure that conflict and grievance resolu-  
19          tion processes are culturally and linguistically sen-  
20          sitive and capable of identifying, preventing, and re-  
21          solving cross-cultural conflicts or complaints by pa-  
22          tients;

23          “(13) regularly make available to the public in-  
24          formation about their progress and successful inno-  
25          vations in implementing the standards under this

1 section and provide public notice in their commu-  
 2 nities about the availability of this information; and

3 “(14) if requested, regularly make available to  
 4 the head of each Federal entity from which Federal  
 5 funds are received, information about their progress  
 6 and successful innovations in implementing the  
 7 standards under this section as required by the head  
 8 of such entity.

9 **“SEC. 3103. ROBERT T. MATSUI CENTER FOR CULTURAL**  
 10 **AND LINGUISTIC COMPETENCE IN HEALTH**  
 11 **CARE.**

12 “(a) ESTABLISHMENT.—The Secretary, acting  
 13 through the Director of the Agency for Healthcare Re-  
 14 search and Quality, shall establish and support a center  
 15 to be known as the ‘Robert T. Matsui Center for Cultural  
 16 and Linguistic Competence in Health Care’ (referred to  
 17 in this section as the ‘Center’) to carry out the following  
 18 activities:

19 “(1) INTERPRETATION SERVICES.—The Center  
 20 shall provide resources via the Internet to identify  
 21 and link health care providers to competent inter-  
 22 preter and translation services.

23 “(2) TRANSLATION OF WRITTEN MATERIAL.—

24 “(A) The Center shall provide, directly or  
 25 through contract, vital documents from com-

1           petent translation services for providers of  
2           health care and health care-related services at  
3           no cost to such providers. Materials may be  
4           submitted for translation into non-English lan-  
5           guages. Translation services shall be provided  
6           in a timely and reasonable manner and in ac-  
7           cordance with the guidelines and standards set  
8           forth in subsection (c) when such standards be-  
9           come available. The quality of such translation  
10          services shall be monitored and reported pub-  
11          licly.

12                 “(B) For each form developed or revised  
13           by the Secretary that will be used by LEP indi-  
14           viduals in health care or health care-related set-  
15           tings, the Center shall translate the form, at a  
16           minimum, into the top 15 non-English lan-  
17           guages in the United States according to the  
18           most recent data from the American Commu-  
19           nity Survey or its replacement. The translation  
20           must be completed within 45 days of the Sec-  
21           retary receiving final approval of the form from  
22           the Office of Management and Budget.

23                 “(3) TOLL-FREE CUSTOMER SERVICE TELE-  
24          PHONE NUMBER.—The Center shall provide,



1 through a toll-free number, a customer service line  
2 for LEP individuals—

3 “(A) to obtain information about federally  
4 conducted or funded health programs, including  
5 Medicare, Medicaid, and SCHIP;

6 “(B) to obtain assistance with applying for  
7 or accessing these programs and understanding  
8 Federal notices written in English; and

9 “(C) to learn how to access language serv-  
10 ices.

11 “(4) HEALTH INFORMATION CLEARING-  
12 HOUSE.—

13 “(A) IN GENERAL.—The Center shall de-  
14 velop and maintain an information clearing-  
15 house to facilitate the provision of language  
16 services by providers of health care and health  
17 care-related services to reduce medical errors,  
18 improve medical outcomes, reduce health care  
19 costs caused by miscommunication with individ-  
20 uals with limited English proficiency, and re-  
21 duce or eliminate the duplication of effort to  
22 translate materials. The clearinghouse shall  
23 make such information available on the Internet  
24 and in print. Such information shall include the

1 information described in the succeeding provi-  
2 sions of this paragraph.

3 “(B) DOCUMENT TEMPLATES.—The Cen-  
4 ter shall collect and evaluate for accuracy, de-  
5 velop, and make available templates for stand-  
6 ard documents that are necessary for patients  
7 and consumers to access and make educated de-  
8 cisions about their health care, including the  
9 following:

10 “(i) Administrative and legal docu-  
11 ments, including—

12 “(I) intake forms;

13 “(II) Medicare, Medicaid, and  
14 SCHIP forms, including eligibility in-  
15 formation;

16 “(III) forms informing patient of  
17 HIPAA compliance and consent; and

18 “(IV) documents concerning in-  
19 formed consent, advanced directives,  
20 and waivers of rights.

21 “(ii) Clinical information, such as how  
22 to take medications, how to prevent trans-  
23 mission of a contagious disease, and other  
24 prevention and treatment instructions.

1           “(iii) Public health, patient education,  
2           and outreach materials, such as immuniza-  
3           tion notices, health warnings, or screening  
4           notices.

5           “(iv) Additional health or health care-  
6           related materials as determined appro-  
7           priate by the Director of the Center.

8           “(C) STRUCTURE OF FORMS.—The oper-  
9           ating the clearinghouse, the Center shall—

10           “(i) ensure that the documents posted  
11           in English and non-English languages are  
12           culturally appropriate;

13           “(ii) allow public review of the docu-  
14           ments before dissemination in order to en-  
15           sure that the documents are understand-  
16           able and culturally appropriate for the tar-  
17           get populations;

18           “(iii) allow health care providers to  
19           customize the documents for their use;

20           “(iv) facilitate access to these docu-  
21           ments;

22           “(v) provide technical assistance with  
23           respect to the access and use of such infor-  
24           mation; and

1 “(vi) carry out any other activities the  
2 Secretary determines to be useful to fulfill  
3 the purposes of the clearinghouse.

4 “(D) LANGUAGE ASSISTANCE PRO-  
5 GRAMS.—The Center shall provide for the col-  
6 lection and dissemination of information on cur-  
7 rent examples of language assistance programs  
8 and strategies to improve language services for  
9 LEP individuals, including case studies using  
10 de-identified patient information, program sum-  
11 maries, and program evaluations.

12 “(E) CULTURAL AND LINGUISTIC COM-  
13 PETENCE MATERIALS.—The Center shall pro-  
14 vide information relating to culturally and lin-  
15 guistically competent health care for minority  
16 populations residing in the United States to all  
17 health care providers and health care-related  
18 services at no cost. Such information shall in-  
19 clude—

20 “(i) tenets of culturally and linguis-  
21 tically competent care;

22 “(ii) cultural and linguistic com-  
23 petence self-assessment tools;

24 “(iii) cultural and linguistic com-  
25 petence training tools;

1                   “(iv) strategic plans to increase cul-  
2                   tural and linguistic competence in different  
3                   types of providers of health care and  
4                   health care-related services, including re-  
5                   gional collaborations among health care or-  
6                   ganizations; and

7                   “(v) cultural and linguistic com-  
8                   petence information for educators, practi-  
9                   tioners, and researchers.

10                  “(F) INFORMATION ABOUT PROGRESS.—  
11                  The Center shall regularly collect and make  
12                  publicly available information about the  
13                  progress of entities receiving grants under sec-  
14                  tion 3104 regarding successful innovations in  
15                  implementing the obligations under this sub-  
16                  section and provide public notice in the entities’  
17                  communities about the availability of this infor-  
18                  mation;

19                  “(b) DIRECTOR.—The Center shall be headed by a  
20                  Director who shall be appointed by, and who shall report  
21                  to, the Director of the Agency for Healthcare Research  
22                  and Quality.

23                  “(c) INTERPRETATION AND TRANSLATION GUIDE-  
24                  LINES AND STANDARDS.—The Center shall convene a  
25                  working group to develop and adopt interpretation and

1 translation quality guidelines and standards for use by the  
2 Center. The guidelines and standards must be sufficient  
3 to ensure that LEP individuals have the equal opportunity  
4 to benefit from health care services to the same extent  
5 as non-LEP individuals. The guidelines and standards  
6 shall address the training, assessment and certification of  
7 individuals to provide competent interpreter and trans-  
8 lator services to work in health care and health care-re-  
9 lated settings and of bilingual staff who provide services  
10 directly in non-English languages. The working group may  
11 develop different guidelines and standards for bilingual  
12 staff, interpreters, and translators.

13 “(d) MEMBERSHIP.—

14 “(1) QUALIFICATIONS.—The Working Group  
15 shall consist of 14 members as follows:

16 “(A) Four members from organizations  
17 that advocate on behalf of LEP individuals.

18 “(B) One member who represents a profes-  
19 sional interpreter association (that is not the  
20 National Council on Interpreting in Health  
21 Care) or translator association.

22 “(C) One member from a non-profit com-  
23 munity based organization that provides lan-  
24 guage services.

1           “(D) Three members recommended by the  
2           National Council on Interpreting in Health  
3           Care, including one individual who is a  
4           professional interpreter.

5           “(E) Four members who are health care  
6           providers or represent health care provider as-  
7           sociations, including one individual who rep-  
8           resents a health care practice of fewer than 5  
9           clinicians.

10           “(F) One member who works in or has ex-  
11           tensive knowledge of issues related to health  
12           care risk management.

13           “(2) GEOGRAPHIC REPRESENTATION.—The  
14           membership of the Working Group shall reflect a  
15           broad geographic representation including both  
16           urban and rural representatives, including represent-  
17           atives of the United States territories.

18           “(3) PROHIBITED APPOINTMENTS.—Members  
19           of the Working Group shall not include Members of  
20           Congress or other elected Federal, State, or local  
21           government officials.

22           “(4) VACANCIES.—Any vacancies in the Work-  
23           ing Group shall not affect the power and duties of  
24           the Working Group but shall be filled in the same  
25           manner as the original appointment.

1           “(5) SUBCOMMITTEES.—The Working Group  
2           may establish subcommittees if doing so increases  
3           the efficiency of the Working Group in completing  
4           its tasks, including subcommittees to develop dif-  
5           ferent guidelines and standards for interpreters,  
6           translators, and bilingual staff.

7           “(6) ADVISORY PANEL TO THE WORKING  
8           GROUP.—The Working Group shall consult with the  
9           Advisory Panel in the development of the guidelines  
10          and standards. The Advisory Panel shall include—

11               “(A) representatives from the American  
12               Translators Association, Association of Lan-  
13               guage Companies, the National Center for  
14               State Courts, and States which have developed  
15               interpreter standards such as California, Mas-  
16               sachusetts and Oregon who have experience in  
17               the development or implementation of their or-  
18               ganizations’ interpreter and translator certifi-  
19               cation programs;

20               “(B) Federal agencies including the Office  
21               for Civil Rights, the Office of Minority Health,  
22               and the Centers for Medicare & Medicaid Serv-  
23               ices and the National Center on Minority  
24               Health and Health Disparities; and



1           “(C) other individuals or entities deter-  
2 mined appropriate by the Secretary who have  
3 specific expertise that will be useful to the  
4 Working Group.

5           “(7) PUBLICATION.—

6           “(A) DRAFT STANDARDS.—Not later than  
7 18 months after the date of enactment of this  
8 title, the Working Group shall—

9           “(i) prepare and make available to the  
10 public through the Internet, the Federal  
11 Register, and other appropriate public  
12 channels, a proposed set of interpretation  
13 and translation guidelines and standards  
14 for training, assessment, and certification;  
15 and

16           “(ii) accept public comment on such  
17 guidelines and standards for a period of  
18 not less than 90 days.

19           “(B) FINAL STANDARDS.—Not later than  
20 120 days after the expiration of the public com-  
21 ment period described in subparagraph (A), the  
22 Director of the Agency for Healthcare Research  
23 and Quality shall publish, after consultation  
24 with and the approval of the Working Group,

1 final guidelines and standards in the Federal  
2 Register and on the Internet.

3 “(C) TESTING DEVELOPMENT.—Not later  
4 than 120 days after the publication of the final  
5 recommendations described in subparagraph  
6 (B), the Director of the Agency for Healthcare  
7 Research and Quality shall, if deemed necessary  
8 by the Working Group, enter into a contract  
9 with an entity experienced in the development  
10 of designing certification tests in language re-  
11 lated fields to develop such tests as may be nec-  
12 essary to implement the guidelines and stand-  
13 ards.

14 “(D) PILOT PROJECT.—

15 “(i) Not later than 120 days after  
16 completion of the test development de-  
17 scribed in subparagraph (C) or after publi-  
18 cation of the final guidelines and stand-  
19 ards, whichever is later, the Secretary shall  
20 design, fund, and implement a pilot project  
21 in up to 50 geographically and demo-  
22 graphically diverse sites, two of which must  
23 be in the U.S. territory, to test and evalu-  
24 ate implementation of the recommenda-  
25 tions.

1           “(ii) The Secretary shall consult with  
2           the Working Group and the Advisory  
3           Panel in development of the pilot project  
4           and report progress to the Working Group  
5           on an ongoing basis.

6           “(iii) The pilot project shall include  
7           interpreters and translators working with  
8           various provider types, including small  
9           group practices, hospitals, and community  
10          health clinics, and shall include broad geo-  
11          graphic representation including both  
12          urban and rural representatives.

13          “(iv) The pilot project shall operate  
14          for not less than two nor more than four  
15          years, as determined by the Secretary.

16          “(v) If the Working Group determines  
17          that any revisions to guidelines and stand-  
18          ards are necessary as a result of the pilot  
19          project, it shall revise such guidelines and  
20          standards and the Director of the Agency  
21          for Healthcare Research and Quality shall  
22          publish the revisions in the Federal Reg-  
23          ister for notice and comment. Not later  
24          than 120 days after the expiration of the  
25          public comment period on such revisions,

1 the Director of the Agency for Healthcare  
2 Research and Quality shall publish, after  
3 consultation with and the approval of the  
4 Working Group, final revisions to the  
5 guidelines and standards in the Federal  
6 Register and on the Internet.

7 “(8) ADMINISTRATION.—

8 “(A) CHAIRPERSON.—Not later than 15  
9 days after the date on which all members of the  
10 Working Group have been appointed under sub-  
11 section (d), the Working Group shall designate  
12 its chairperson.

13 “(B) COMPENSATION.—While serving on  
14 the business of the Working Group (including  
15 travel time), a member of the Working Group  
16 or the Advisory Panel shall be entitled to com-  
17 pensation at the per diem equivalent of the rate  
18 provided for level IV of the Executive Schedule  
19 under section 5315 of title 5, United States  
20 Code, and while so serving away from home and  
21 the member’s regular place of business, a mem-  
22 ber may be allowed travel expenses, as author-  
23 ized by the chairperson of the Working Group.  
24 For purposes of pay and employment benefits,  
25 rights, and privileges, all personnel of the

1 Working Group shall be treated as if they were  
2 employees of the House of Representatives.

3 “(C) INFORMATION FROM FEDERAL AGEN-  
4 CIES.—The Working Group may secure directly  
5 from any Federal department or agency such  
6 information as the Working Group considers  
7 necessary to carry out this section. Upon re-  
8 quest of the Working Group, the head of such  
9 department or agency shall furnish such infor-  
10 mation. Any information that contains individ-  
11 ually identifiable information received by the  
12 Working Group shall not be disseminated or  
13 disclosed outside of the Working Group and  
14 shall not be used except by the Working Group.

15 “(D) DETAIL.—Not more than 10 Federal  
16 Government employees employed by the Depart-  
17 ment of Health and Human Services may be  
18 detailed to staff the Working Group under this  
19 section without further reimbursement. Any de-  
20 tail of an employee shall be without interruption  
21 or loss of civil service status or privilege.

22 “(E) TEMPORARY AND INTERMITTENT  
23 SERVICES.—The Working Group may procure  
24 temporary and intermittent services under sec-  
25 tion 3109(b) of title 5, United States Code, at

1 rates for individuals which do not exceed the  
2 daily equivalent of the annual rate of basic pay  
3 prescribed for level V of the Executive Schedule  
4 under section 5316 of such title.

5 “(F) AUTHORIZATION OF APPROPRIA-  
6 TIONS.—There are authorized to be appro-  
7 priated to carry out this section such sums as  
8 may be necessary for the activities of the Work-  
9 ing Group and Advisory Panel for each of fiscal  
10 years 2010 through 2014, and for the funding  
11 of the pilot project.

12 “(9) DEEMED STATUS.—

13 “(A) CERTIFICATION BY PRIVATE ORGANI-  
14 ZATION.—If a private accreditation organization  
15 establishes training, assessment, or certification  
16 standards for interpreters or translators in  
17 health care which the Secretary determines are  
18 at least equivalent to the training, assessment,  
19 or certification standards promulgated by the  
20 Secretary as described in subsection (c), the  
21 Secretary shall find that all organizations or in-  
22 dividuals accredited by such organization com-  
23 ply also with the standard described in sub-  
24 section (c) if—

1                   “(i) such organization or individual  
2                   authorizes the organization to release to  
3                   the Secretary upon the Secretary’s request  
4                   (or such State agency as the Secretary  
5                   may designate) a copy of the most current  
6                   accreditation survey of such organization  
7                   or individual made by the organization, to-  
8                   gether with any other information directly  
9                   related to the survey as the Secretary may  
10                  require (including corrective action plans);  
11                  and

12                  “(ii) such organization releases such a  
13                  copy and any such information to the Sec-  
14                  retary.

15                  “(B) CERTIFICATION BY A STATE OR LO-  
16                  CALITY.—If a State or locality has or estab-  
17                  lishes training, assessment, or certification  
18                  standards for interpreters or translators in  
19                  health care which the Secretary determines are  
20                  at least equivalent to the training, assessment,  
21                  or certification standards promulgated by the  
22                  Secretary as described in subsection (c), the  
23                  Secretary shall find that all organizations or in-  
24                  dividuals accredited by such State or locality

1           comply also with the standard described in sub-  
2           section (c) if—

3                   “(i) such organization or individual  
4                   authorizes the State or locality to release  
5                   to the Secretary upon his request (or such  
6                   State agency as the Secretary may des-  
7                   ignate) a copy of the most current accredi-  
8                   tation survey of such organization or indi-  
9                   vidual made by such State or locality, to-  
10                  gether with any other information directly  
11                  related to the survey as the Secretary may  
12                  require (including corrective action plans);  
13                  and

14                  “(ii) such State or locality releases  
15                  such a copy and any such information to  
16                  the Secretary.

17                  “(C) TIMELY ACTION ON APPLICATION.—

18                  The Secretary shall determine, within 210 days  
19                  after the date the Secretary receives an applica-  
20                  tion by a private accrediting organization,  
21                  State, or locality whether the process of the pri-  
22                  vate accrediting organization, State, or locality  
23                  meets the requirements with respect to training,  
24                  assessment, or certification standards for inter-  
25                  preters or translators with respect to which



standards the application is made. The Secretary may not deny an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, training, assessment, or certification standards for interpreters or translators.

“(D) DISCLOSURE OF ACCREDITATION SURVEY.—The Secretary may not disclose any accreditation survey made and released to him by the National Council on Interpreting in Health Care or any State or locality of an accredited organization or individual, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

“(E) DEFICIENCIES.—If the Secretary finds that an accredited organization or individual has significant deficiencies (as defined in regulations pertaining to the training, assessment, or certification standards), the organization or individual shall, after the date of notice of such finding to the organization and for such period as may be prescribed in regulations, be deemed not to meet the conditions or require-

1           ments the organization or individual has been  
2           treated as meeting pursuant to subparagraph  
3           (A).

4           “(e) AVAILABILITY OF LANGUAGE ACCESS.—The Di-  
5   rector shall collaborate with the Administrator of the Of-  
6   fice of Minority Health, the Administrator of the Centers  
7   for Medicare & Medicaid Services, and the Administrator  
8   of the Health Resources and Services Administration to  
9   notify health care providers and health care organizations  
10   about the availability of language access services by the  
11   Center.

12          “(f) EDUCATION.—The Secretary, directly or through  
13   contract, shall undertake a national education campaign  
14   to inform providers, LEP individuals, and health profes-  
15   sional and graduate schools about—

16           “(1) Federal and State laws and guidelines gov-  
17   erning access to language services;

18           “(2) the value of using trained interpreters and  
19   the risks associated with using family members,  
20   friends, minors, and untrained bilingual staff;

21           “(3) funding sources for developing and imple-  
22   menting language services; and

23           “(4) promising practices to effectively provide  
24   language services.

1       “(g) AUTHORIZATION OF APPROPRIATIONS.—In ad-  
 2 dition to the amounts authorized under subsection  
 3 (e)(8)(F), there are authorized to be appropriated to carry  
 4 out this section such sums as may be necessary for each  
 5 of fiscal years 2010 through 2014.

6       **“SEC. 3104. INNOVATIONS IN CULTURAL AND LINGUISTIC**  
 7                               **COMPETENCE GRANTS.**

8       “(a) IN GENERAL.—The Secretary, acting through  
 9 the Director of the Agency for Healthcare Research and  
 10 Quality, shall award grants to eligible entities to enable  
 11 such entities to design, implement, and evaluate innova-  
 12 tive, cost-effective programs to improve language access  
 13 in health care for individuals with limited English pro-  
 14 ficiency. The Director of the Agency for Healthcare Re-  
 15 search and Quality shall coordinate with, and ensure the  
 16 participation of, other agencies including but not limited  
 17 to the Health Resources and Services Administration, the  
 18 Center on Minority Health and Health Disparities at the  
 19 National Institutes of Health, and the Office of Minority  
 20 Health, regarding the design and evaluation of the grants  
 21 program.

22       “(b) ELIGIBILITY.—To be eligible to receive a grant  
 23 under subsection (a) an entity shall—

24               “(1) be—

1           “(A) a city, county, Indian tribe, State,  
2           territory or subdivision thereof;

3           “(B) an organization described in section  
4           501(c)(3) of the Internal Revenue Code of  
5           1986;

6           “(C) a community health center or commu-  
7           nity clinic;

8           “(D) a solo or group physician practice;

9           “(E) an integrated health care delivery  
10          system;

11          “(F) public hospital;

12          “(G) health care group, university, or col-  
13          lege; or

14          “(H) other entity designated by the Sec-  
15          retary; and

16          “(2) prepare and submit to the Secretary an  
17          application, at such time, in such manner, and ac-  
18          companied by such additional information as the  
19          Secretary may require.

20          “(c) USE OF FUNDS.—An entity shall use funds re-  
21          ceived under a grant under this section to—

22               “(1) develop, implement, and evaluate models of  
23               providing competence interpretation services through  
24               on-site interpretation, telephonic interpretation, or  
25               video interpretation;

1           “(2) implement strategies to recruit, retain, and  
2           promote individuals at all levels of the organization  
3           to maintain a diverse staff and leadership that can  
4           promote and provide language services to patient  
5           populations of the service area of the organization;

6           “(3) develop and maintain a needs assessment  
7           that identifies the current demographic, cultural,  
8           and epidemiological profile of the community to ac-  
9           curately plan for and implement language services  
10          needed in service area of the organization;

11          “(4) develop a strategic plan to implement lan-  
12          guage services;

13          “(5) develop participatory, collaborative part-  
14          nerships with communities encompassing the LEP  
15          patient populations being served to gain input in de-  
16          signing and implementing language services;

17          “(6) develop and implement grievance resolu-  
18          tion processes that are culturally and linguistically  
19          sensitive and capable of identifying, preventing, and  
20          resolving complaints by LEP individuals; or

21          “(7) develop short-term medical interpretation  
22          training courses and incentives for bilingual health  
23          care staff who are asked to interpret in the work-  
24          place;

1           “(8) develop formal training programs for indi-  
2           viduals interested in becoming dedicated health care  
3           interpreters and culturally competent providers;

4           “(9) provide staff language training instruction,  
5           which shall include information on the practical limi-  
6           tations of such instruction for non-native speakers;  
7           and

8           “(10) develop other language assistance services  
9           as determined appropriate by the Secretary; and

10          “(11) ensure that, consistent with the privacy  
11          protections provided for under the regulations pro-  
12          mulgated under section 264(c) of the Health Insur-  
13          ance Portability and Accountability Act of 1996 (42  
14          U.S.C. 1320d–2 note), and any applicable State pri-  
15          vacy laws, data on the individual patient or recipi-  
16          ent’s race, ethnicity, and primary language are col-  
17          lected (and periodically updated) in health records  
18          and integrated into the organization’s information  
19          management systems or any similar system used to  
20          store and retrieve data;

21          “(d) PRIORITY.—In awarding grants under this sec-  
22          tion, the Secretary shall give priority to entities that pri-  
23          marily engage in providing direct care and that have devel-  
24          oped partnerships with community organizations or with  
25          agencies with experience language access.

1 “(e) EVALUATION.—

2 “(1) An entity that receives a grant under this  
3 section shall submit to the Secretary an evaluation  
4 that describes, in the manner and to the extent re-  
5 quired by the Secretary, the activities carried out  
6 with funds received under the grant, and how such  
7 activities improved access to health and health care-  
8 related services and the quality of health care for in-  
9 dividuals with limited English proficiency. Such eval-  
10 uation shall be collected and disseminated through  
11 the Robert T. Matsui Center for Cultural and Lin-  
12 guistic Competence in Health Care established under  
13 section 3103. The Director of the Agency for  
14 Healthcare Research and Quality shall notify grant-  
15 ees of the availability of technical assistance for the  
16 evaluation and provide such assistance upon request.

17 “(2) The Director of the Agency for Healthcare  
18 Research and Quality shall evaluate or arrange with  
19 other individuals or organizations to evaluate  
20 projects funded under this section.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
22 is authorized to be appropriated to carry out this section,  
23 \$5,000,000 for each of fiscal years 2010 through 2014.

1 **“SEC. 3105. RESEARCH ON CULTURAL AND LANGUAGE COM-**  
2 **PETENCE.**

3 “(a) IN GENERAL.—The Secretary, acting through  
4 the Director of the Agency for Healthcare Research and  
5 Quality, shall expand research concerning language access  
6 in the provision of health care.

7 “(b) ELIGIBILITY.—The Director of the Agency for  
8 Healthcare Research and Quality may conduct the re-  
9 search described in subsection (a) or enter into contracts  
10 with other individuals or organizations to do so.

11 “(c) USE OF FUNDS.—Research under this section  
12 shall be designed to do one or more of the following:

13 “(1) To identify the barriers to mental and be-  
14 havioral services that are faced by LEP individuals.

15 “(2) To identify health care providers’ and  
16 health administrators’ attitudes, knowledge, and  
17 awareness of the barriers to quality health care serv-  
18 ices that are faced by LEP individuals.

19 “(3) To identify optimal approaches for deliv-  
20 ering language access.

21 “(4) To identify best practices for data collec-  
22 tion, including—

23 “(A) the collection by providers of health  
24 care and health care-related services of data on  
25 the race, ethnicity, and primary language of re-  
26 cipients of such services, taking into account ex-



1           isting research conducted by the Government or  
2           private sector;

3           “(B) the development and implementation  
4           of data collection and reporting systems; and

5           “(C) effective privacy safeguards for col-  
6           lected data.

7           “(5) To develop a minimum data collection set  
8           for primary language.

9           “(6) To evaluate the most effective ways in  
10          which the Department can create or coordinate, and  
11          then subsidize or otherwise fund telephonic interpre-  
12          tation providers for health care providers, taking  
13          into consideration, among other factors, the flexi-  
14          bility necessary for such a system to accommodate  
15          variations in—

16               “(A) provider type;

17               “(B) languages needed and their frequency  
18               of use;

19               “(C) type of encounter;

20               “(D) time of encounter, including regular  
21               business hours and after hours; and

22               “(E) location of encounter.

23          “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
24          are authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years  
 2 2010 through 2014.”.

3 **SEC. 102. FEDERAL REIMBURSEMENT FOR CULTURALLY**  
 4 **AND LINGUISTICALLY APPROPRIATE SERV-**  
 5 **ICES UNDER THE MEDICARE, MEDICAID AND**  
 6 **THE STATE CHILDREN’S HEALTH INSURANCE**  
 7 **PROGRAM.**

8 (a) MEDICARE.—Title XVIII of the Social Security  
 9 Act is amended by adding at the end the following new  
 10 section:

11 “MEDICARE SUPPORT FOR LANGUAGE SERVICES

12 “SEC. 1899.

13 “(a) ENSURING APPROPRIATE PAYMENT FOR THE  
 14 FURNISHING OF LINGUISTICALLY APPROPRIATE LAN-  
 15 GUAGE SERVICES TO ALL MEDICARE BENEFICIARIES.—

16 “(b) TEMPORARY COST-BASED PAYMENTS FOR LAN-  
 17 GUAGE SERVICES TO HOSPITALS.—

18 “(1) IN GENERAL.—Not later than 90 days  
 19 after enactment of this section, the Secretary shall  
 20 initiate quarterly payments to all hospitals that are  
 21 certified as Medicare providers (including short-term  
 22 acute inpatient hospitals, long-term care hospitals,  
 23 inpatient rehabilitation facilities, children’s, cancer,  
 24 psychiatric, and critical access hospitals) to pay for  
 25 the costs of providing language services to limited  
 26 English proficient Medicare beneficiaries. These pay-

1       ments shall cover the provision of language services  
2       by hospitals in inpatient and outpatient settings.  
3       These payments shall continue until the Secretary  
4       develops and implements reimbursement standards  
5       for language services pursuant to the process set  
6       forth in subsection (b).

7               “(2) DETERMINATION OF TEMPORARY PAY-  
8       MENTS.—Payments under paragraph (1) shall be  
9       calculated based on the estimated numbers of LEP  
10      Medicare beneficiaries in a hospital’s service area  
11      utilizing—

12               “(A) data on the numbers of LEP individ-  
13      uals (defined for purposes of this paragraph as  
14      individuals who speak English less than ‘very  
15      well’) from the most recently available data  
16      from the Bureau of the Census; or

17               “(B) the hospital’s own data if—

18                       “(i) the hospital routinely collects  
19                      data on patients’ primary language or need  
20                      for an interpreter in both in- and out-pa-  
21                      tient settings;

22                       “(ii) the data collection system used  
23                      by the hospital is, as determined by the  
24                      Secretary, likely to yield accurate data re-

1           garding the number of LEP individuals  
2           served by the hospital, and,

3           “(iii) the hospital’s data documents  
4           greater numbers of LEP individuals than  
5           does the data described in clause (i).

6           “(C) DISTRIBUTION OF FUNDS.—On a  
7           quarterly basis, the Secretary shall pay  
8           amounts directly to eligible hospitals to pay for  
9           the costs of providing language services to LEP  
10          Medicare beneficiaries.

11          “(D) METHODOLOGIES.—In establishing a  
12          methodology for temporary payments, the Sec-  
13          retary may establish one or more payment  
14          methodologies for inpatient and outpatient set-  
15          tings.

16          “(3) REPORTING REQUIREMENTS.—Hospitals  
17          receiving payment under paragraph (1) shall provide  
18          the Secretary with two reports on—

19               “(A) the number of Medicare beneficiaries  
20               to whom language services are provided;

21               “(B) the languages of those Medicare  
22               beneficiaries;

23               “(C) the types of language services pro-  
24               vided (such as provision of services directly in

1 non-English language by a health care provider  
2 or use of an interpreter);

3 “(D) type of interpretation (such as in-per-  
4 son, telephonic, or video interpretation);

5 “(E) the methods of providing language  
6 services (staff, contract with external inde-  
7 pendent contractors, or agencies);

8 “(F) the length of time for each interpre-  
9 tation encounter; and

10 “(G) the costs of providing language serv-  
11 ices (whether actual or estimated, as deter-  
12 mined by the Secretary).

13 “(4) NO COST-SHARING.—There shall be no  
14 cost-sharing for language services provided as tem-  
15 porary payments to hospitals.

16 “(5) AUTHORIZATION OF APPROPRIATIONS.—  
17 There is authorized to be appropriated to carry out  
18 this subsection such sums as may be necessary for  
19 each of fiscal years 2010 through 2014.

20 “(c) DEVELOPMENT OF PAYMENT AMOUNTS FOR  
21 LANGUAGE SERVICES.—

22 “(1) IN GENERAL.—Not later than 6 months  
23 after enactment of this section, the Secretary shall  
24 convene a Working Group to advise the Secretary on  
25 the development of payment amounts that are based

1 on hospital-reported costs for language services pro-  
2 vided to LEP Medicare beneficiaries. Reimburse-  
3 ment shall apply to all Medicare-covered services  
4 furnished by certified providers to eligible bene-  
5 ficiaries, whether covered under parts A and B or  
6 under the Medicare Advantage program under  
7 part C.

8 “(2) VARIATIONS.—The Secretary, in consulta-  
9 tion with the Working Group, may establish vari-  
10 ations within the reimbursement system based upon  
11 available delivery methods and costs for providing  
12 language services including such factors as—

13 “(A) the type of language services provided  
14 (such as provision of services directly in a non-  
15 English language by a health care provider or  
16 use of an interpreter);

17 “(B) type of interpretation services pro-  
18 vided (such as in-person, telephonic, or video in-  
19 terpretation);

20 “(C) the methods and costs of providing  
21 language services (including the costs of pro-  
22 viding language services with internal staff or  
23 through contract with external independent con-  
24 tractors or agencies);

1           “(D) providing services for languages not  
2           frequently encountered in the United States;  
3           and

4           “(E) providing services in rural areas.

5           “(3) NO COST-SHARING.—There shall be no  
6           cost-sharing for language services provided as pay-  
7           ments to hospitals under this subsection.

8           “(4) LIMITATIONS.—

9           “(A) IN GENERAL.—Reimbursement shall  
10          only be provided to hospitals under this sub-  
11          section that report their costs of providing lan-  
12          guage services, including information on the  
13          factors described in paragraph (1) that are uti-  
14          lized in establishing the reimbursement rates  
15          and any other information specified by the Sec-  
16          retary.

17          “(B) USE OF INTERPRETER OR TRANS-  
18          LATION SERVICES.—

19                 “(i) IN GENERAL.—Reimbursement  
20                 shall be provided under this subsection  
21                 only to hospitals that utilize interpreter or  
22                 translation services.

23                 “(ii) INTERPRETER SERVICES DE-  
24                 FINED.—In this paragraph the term ‘inter-  
25                 preter services’ means services designed to

1 provide a competent trans-language ren-  
2 dition of a spoken message in which an in-  
3 terpreter comprehends the source language  
4 and can speak comprehensively in the tar-  
5 get language to convey the meaning in-  
6 tended in the source language. Such inter-  
7 preter shall know health and health-related  
8 terminology and provide accurate interpre-  
9 tations by choosing equivalent expressions  
10 that convey the best matching and mean-  
11 ing to the source language and captures, to  
12 the greatest possible extent, all nuances in-  
13 tended in the source message.

14 “(iii) INTERPRETER DEFINED.—In  
15 this paragraph, the he term ‘interpreter’  
16 means an individual who transmits a spo-  
17 ken message from one language into an-  
18 other, faithfully, accurately, and objec-  
19 tively. Such term includes an individual  
20 who provide in-person, telephonic, and  
21 video interpretation and also includes an  
22 individual who is employed or contracted  
23 by those who provide benefits under sec-  
24 tion 1832.



1           “(iv) TRANSLATION.—In this para-  
2 graph, the term ‘translation’ means the  
3 competent transmission of a written mes-  
4 sage in one language into a written mes-  
5 sage in another language.

6           “(v) EXEMPTIONS.—The require-  
7 ments of clauses (i) and (ii) shall not  
8 apply—

9           “(I) when a individual (who has  
10 been informed in the individual’s pri-  
11 mary language of the availability of  
12 free interpreter and translation serv-  
13 ices) requests the use of family,  
14 friends or other persons untrained in  
15 interpretation or translation; and

16          “(II) when a medical emergency  
17 exists and the delay directly associ-  
18 ated with obtaining a competent inter-  
19 preter or translation services would  
20 jeopardize the health of the individual.

21 Nothing in this clause shall exempt emer-  
22 gency rooms or similar entities that regu-  
23 larly provide health care services in med-  
24 ical emergencies from having in place sys-

1           tems to provide competent interpreter and  
2           translation services without undue delay.

3           “(5) WORKING GROUP.—The Secretary shall es-  
4           tablish a Working Group (in this subsection referred  
5           to as the ‘Working Group’) to develop the payment  
6           amounts under this paragraph. Such Working Group  
7           include representatives from the American Hospital  
8           Association, National Association of Public Hos-  
9           pitals and Health Systems, Association of Language  
10          Companies, the National Council of Interpreting in  
11          Health Care, organizations that advocate on behalf  
12          of limited English proficient individuals, and other  
13          individuals or entities determined appropriate by the  
14          Secretary, including those who have specific exper-  
15          tise in either developing cost-based reimbursement  
16          or provision of language services, that will be useful.

17          “(6) PUBLICATION.—

18                 “(A) PROPOSED REIMBURSEMENT STAND-  
19                 ARDS.—Not later than 18 months after the  
20                 date of enactment of this section, the Secretary  
21                 shall, contingent upon consultation with and ap-  
22                 proval of the Working Group—

23                         “(i) prepare and make available to the  
24                         public through the Internet, the Federal  
25                         Register, and other appropriate public

1 channels, proposed payment amounts  
2 under this subsection based on hospital-re-  
3 ported costs; and

4 “(ii) accept public comment on such  
5 reimbursement standards for a period of  
6 not less than 90 days.

7 “(B) FINAL REIMBURSEMENT STAND-  
8 ARDS.—

9 “(i) IN GENERAL.—Not later than  
10 120 days after the expiration of the public  
11 comment period described in subparagraph  
12 (A), the Secretary shall publish, after con-  
13 sultation with and the approval of the  
14 Working Group, final reimbursement  
15 standards in the Federal Register and on  
16 the Internet. The final reimbursement  
17 standards shall go into effect within six  
18 months of the date of such publication.

19 “(ii) TRAINING.—Between such publi-  
20 cation and effective dates, the Secretary  
21 shall provide training and technical assist-  
22 ance to hospitals on the final reimburse-  
23 ment standards. As necessary, the Sec-  
24 retary shall continue to provide training

1           and technical assistance after the reim-  
2           bursement standards becomes effective.

3           “(iii) PHASE-OUT.—When the final  
4           reimbursement standards go into effect,  
5           the temporary adjustments described in  
6           subsection (a) shall be phased out over a  
7           one-year period as hospitals implement the  
8           new reimbursement rates. Final reimburse-  
9           ment rates shall not be constrained at the  
10          level of total temporary adjustments. Re-  
11          imbursement shall be set at the level of the  
12          costs of language services at eligible hos-  
13          pitals.

14       “(d) OTHER MEDICARE PAYMENT SYSTEMS.—

15           “(1) PAYMENT SYSTEMS.—

16           “(A) IN GENERAL.—Not later than two  
17          years after enactment of this Act, and using the  
18          guidelines described in subsection (b), the Sec-  
19          retary shall make recommendations to include  
20          payments or adjustments for language services  
21          provided to limited English proficient Medicare  
22          beneficiaries for all of the remaining payment  
23          systems under this title, except the physician  
24          fee schedule under such 1848, including psy-  
25          chiatric hospitals, skilled nursing facilities,

1 home health agencies, rehabilitation facilities,  
2 and long-term care hospitals, as well as the  
3 TEFRA per discharge limit for children's and  
4 cancer hospitals excluded from the inpatient  
5 hospital prospective payment system under sec-  
6 tion 1886(d), the ambulance fee schedule, and  
7 payments to critical access hospitals. Program  
8 costs for language services in critical access  
9 hospitals shall be considered allowable costs  
10 under this title and shall be calculated in the  
11 same manner as other Medicare costs on the  
12 cost report. These costs should be incorporated  
13 into interim payments.

14 “(B) IMPLEMENTATION.—The Secretary  
15 shall implement these payments within three  
16 years.

17 “(C) NO COST-SHARING.—There shall be  
18 no cost-sharing for such language services.

19 “(2) MEDICARE REIMBURSEMENT FOR LAN-  
20 GUAGE SERVICES PROVIDED IN SUPPORT OF PHYSI-  
21 CIAN OFFICE SERVICES.—

22 “(A) STUDY.—The Medicare Payment Ad-  
23 visory Commission shall conduct a study that  
24 examines ways that Medicare can pay for lan-  
25 guage services (including foreign language and

1 sign language) provided in support of physician  
2 office services and other services paid for  
3 through the physician fee schedule under sec-  
4 tion 1848. The report on such study shall in-  
5 clude the following:

6 “(i) Recommendations and effective  
7 methods for adopting a payment method-  
8 ology for on-site interpreters, pursuant to  
9 which such interpreters and agencies could  
10 directly bill Medicare for language services  
11 provided in support of benefits paid for  
12 under section 1832 for a limited English  
13 proficient Medicare patient. For purposes  
14 of this subparagraph, the term ‘on-site in-  
15 terpreters’ include interpreters who work  
16 as independent contractors, for agencies  
17 that provide on-site interpretation, and  
18 who are employed by those who provide  
19 benefits provided under section 1832.

20 “(ii) Recommendations and effective  
21 methods for Medicare contracting directly  
22 with agencies that provide off-site interpre-  
23 tation, including telephonic and video in-  
24 terpretation, pursuant to which such con-  
25 tractors could directly bill Medicare for the

1 services provided in support of benefits  
2 provided under section 1832 for a limited  
3 English proficient Medicare patient.

4 “(iii) Recommendations for modifying  
5 the existing Medicare resource-based rel-  
6 ative value scale (RBRVS) by adding new  
7 procedure codes in the Health Care Com-  
8 mon Procedure Coding System.

9 “(B) REPORT.—Not later than 1 year  
10 after the date of the enactment of this section,  
11 the Commission shall submit to Congress and  
12 the Centers for Medicare & Medicaid Services a  
13 report on the study conducted under subpara-  
14 graph (A), together with recommendations re-  
15 garding the appropriateness of directly reim-  
16 bursing interpreters versus physicians for lan-  
17 guage services provided in support of benefits  
18 provided under section 1832.

19 “(C) IMPLEMENTATION.—

20 “(i) IN GENERAL.—Not later than 1  
21 year after the submission of the report des-  
22 ignated in subparagraph (B), the Secretary  
23 shall publish, after consultation with and  
24 the approval of the Medicare Payment Ad-  
25 visory Commission, final reimbursement

1 standards for language services provided in  
2 support of benefits provided under section  
3 1832. These standards shall be published  
4 in the Federal Register and on the Inter-  
5 net and shall go into effect within six  
6 months of the date of such publication.  
7 The final standards must ensure that—

8 “(I) for the first three years of  
9 implementation, the payments for lan-  
10 guage services do not diminish other  
11 fees provided in support of benefits  
12 provided under section 1832; and

13 “(II) enrollees do not have to pay  
14 any co-pays or cost-sharing for lan-  
15 guage services provided in support of  
16 benefits provided under section 1832.

17 “(ii) TRAINING.—Between such date  
18 of publication and the effective date, the  
19 Secretary shall provide training and tech-  
20 nical assistance to providers covered by the  
21 physician fee schedule under section 1848  
22 on the final reimbursement standards. As  
23 necessary, the Secretary shall continue to  
24 provide training and technical assistance



4 (1) TECHNICAL AMENDMENTS.—

8 “Language Services; Interpreter Services; Interpreter;  
9 Translation; LEP

“(2) For the purposes of this subsection, the term ‘interpreter services’ means services designed to provide a competent trans-language rendition of a spoken message in which an interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language and interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest

1 possible extent, all nuances intended in the source mes-  
2 sage.

3 “(3) The term ‘interpreter’ means an individual who  
4 transmits a spoken message from one language into an-  
5 other, faithfully, accurately, and objectively. Such term in-  
6 cludes individuals who provide in-person, telephonic, and  
7 video interpretation and such term ‘interpreter’ individ-  
8 uals who are employed or contracted by those who provide  
9 benefits provided under section 1832.

10 “(4) The term ‘translation’ means the competent  
11 transmission of a written message in one language into  
12 a written message in another language.

13 “(5) The terms ‘limited English proficient’ and  
14 ‘LEP’, with respect to an individual, means an individual  
15 who speaks a primary language other than English.”.

16 (B) Subsection (aa)(1)(B) of such section  
17 is amended by inserting “, language services as  
18 defined in subsection (hhh),” after “clinical so-  
19 cial worker (as defined in subsection (hh)(1)),”.

20 (C) Section 1833(a) of the Social Security  
21 Act (42 U.S.C. 1395l) is amended—

22 (i) by redesignating paragraph (9) as  
23 paragraph (10); and

24 (ii) by inserting after paragraph (8)  
25 the following new paragraph:

1 “(9) in the case of language services described  
2 in section 1861(hhh), 100 percent of the reasonable  
3 charges for such services.”.

4 (D) Section 1832(a)(2) of such Act (42  
5 U.S.C. 1395k(a)(2)) is amended—

6 (i) by striking “and” at the end of  
7 subparagraph (I);

8 (ii) by striking the period at the end  
9 of subparagraph (K) and inserting “and”;  
10 and

11 (iii) by adding at the end of subpara-  
12 graph (K) the following:

13 “(L) language services (as defined in sec-  
14 tion 1861(hhh) furnished by a interpreter or  
15 translator, whether contracted or employed by  
16 the entity providing benefits under this sec-  
17 tion.”

18 (E) WAIVER OF BUDGET NEUTRALITY.—

19 For the first 3 years after the effective date of  
20 this section, the budget neutrality provision of  
21 section 1848(c)(2)(B)(ii) of the Social Security  
22 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not  
23 apply to language services.

24 (F) EFFECTIVE DATE.—These amend-  
25 ments made by this subsection are effective

1           upon publication of the final reimbursement  
2           standards described in section 1899(b) of the  
3           Social Security Act, as added by subsection (a).

4           (2) MEDICARE PART C AND PART D.—The Sec-  
5           retary of Health and Human Services shall ensure  
6           Medicare Advantage plans participating in Medicare  
7           part C and prescription drug plans participating in  
8           Medicare part D effectively provide language serv-  
9           ices to their enrollees. The Secretary shall require  
10          annual reporting for such plans that includes infor-  
11          mation on internal policies and procedures related to  
12          cultural appropriateness in each of the following  
13          contexts:

14                (A) Collection of data regarding the en-  
15                rollee population.

16                (B) Education of plan staff and contrac-  
17                tors who have routine contact with enrollees re-  
18                garding the diverse needs of the enrollee popu-  
19                lation.

20                (C) Recruitment and retention efforts that  
21                encourage workforce diversity.

22                (D) Evaluation of the health plan's lan-  
23                guage services programs and services with re-  
24                spect to the plan's enrollee population, using

1 processes such as an analysis of complaints and  
2 satisfaction survey results.

3 (E) Methods by which the plan provides in-  
4 formation regarding the ethnic diversity of the  
5 plan’s enrollee population.

6 (F) The periodic provision of educational  
7 information to plan enrollee on the plan’s lan-  
8 guage services and programs. Plans may use  
9 existing means of communications.

10 (c) IMPROVING LANGUAGE SERVICES IN MEDICAID  
11 AND SCHIP.—

12 (1) Section 1903(a)(2)(E) of the Social Secu-  
13 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended  
14 by—

15 (A) striking “translation or interpretation  
16 services” and inserting “language services”;  
17 and

18 (B) striking “children of families” and in-  
19 serting “individuals”.

20 (2) Section 1902(a)(10)(A) of the Social Secu-  
21 rity Act (42 U.S.C. 1396a(a)(10)(A)) is amended by  
22 striking “and (21)” and inserting “(21), and (28)”.

23 (3) Section 1905(a) of the Social Security Act  
24 (42 U.S.C. 1396d(a)) is amended by—

1 (A) in paragraph (27), by striking “and”  
2 at the end;

3 (B) by redesignating paragraph (28) as  
4 paragraph (29); and

5 (C) by inserting after paragraph (27) the  
6 following new paragraph:

7 “(27) language services (including the provision  
8 of health care services directly in a non-English lan-  
9 guage, interpretation, translation, and non-English  
10 signage), provided in a timely manner to limited  
11 English proficient individuals who need language  
12 services in connection with administrative and cov-  
13 ered services; and”.

14 (4) Section 1916(a)(2) of the Social Security  
15 Act (42 U.S.C. 1396o(2)) is amended by—

16 (A) by striking “or” at the end of subpara-  
17 graph (D);

18 (B) by striking “and” at the end of sub-  
19 paragraph (E) and inserting “or”; and

20 (C) by adding at the end the following new  
21 subparagraph:

22 “(F) language services described in section  
23 1905(a)(27); and”.

24 (5) Section 2103 of the Social Security Act (42  
25 U.S.C. 1397cc) is amended—

1 (A) in subsection (a), in the matter before  
2 paragraph (1), by striking “(7)” and inserting  
3 “, (7), and (9)”; and

4 (B) in subsection (c), by adding at the end  
5 the following new paragraph:

6 “(9) LANGUAGE SERVICES.—The child health  
7 assistance provided to a targeted low-income child  
8 shall include coverage of language services (including  
9 the provision of health care services directly in a  
10 non-English language, interpretation, translation  
11 and non-English signage) provided in a timely man-  
12 ner to limited English proficient individuals who  
13 need them, in connection with administrative and  
14 covered services.”; and

15 (C) in subsection (e)(2)—

16 (i) in the heading, by striking “PRE-  
17 VENTIVE” and inserting “CERTAIN”; and

18 (ii) by inserting “or subsection (c)(9)”  
19 after “subsection (c)(1)(C)”.

20 (6) Section 2110(a)(27) of the Social Security  
21 Act (42 U.S.C. 1397jj) is amended by striking  
22 “translation” and inserting “language services as  
23 described in section 2103(c)(7)”.

24 (7) Pursuant to the reporting requirement de-  
25 scribed in section 2107(b)(1) of the Social Security

1 Act (42 U.S.C. 1397gg(b)(1)), the Secretary of  
 2 Health and Human Services shall ensure that States  
 3 collect data on the—

4 (A) primary language of those assisted;  
 5 and

6 (B) for individuals who are minors or inca-  
 7 pacitated, the primary language of the individ-  
 8 ual's parent or guardian.

9 (8) Section 2105(c)(2)(A) of the Social Security  
 10 Act (42 U.S.C. 1397ee(c)) is amended by inserting  
 11 before the period “, except that expenditures pursu-  
 12 ant to section 2105(a)(1)(D)(iv) shall not count to-  
 13 wards this total”.

14 (d) FUNDING LANGUAGE SERVICES FURNISHED BY  
 15 PROVIDERS OF HEALTH CARE AND HEALTH CARE-RE-  
 16 LATED SERVICES THAT SERVE HIGH RATES OF UNIN-  
 17 SURED LEP INDIVIDUALS.—

18 (1) PAYMENT OF COSTS.—

19 (A) IN GENERAL.—Subject to subpara-  
 20 graph (B), the Secretary of Health and Human  
 21 Services shall make payments (on a quarterly  
 22 basis) directly to eligible entities to support the  
 23 provision of language services to limited English  
 24 proficient individuals in an amount equal to an



1           entity’s eligible costs for such services for the  
2           quarter.

3           (B) LIMITATION.—If the amount of funds  
4           appropriated under subparagraph (C) to carry  
5           out this subsection for a fiscal year is insuffi-  
6           cient to ensure that each eligible entity can re-  
7           ceive full payment under subparagraph (A), the  
8           Secretary shall reduce in a pro rata manner the  
9           amount of such payment to each such entity.

10          (C) FUNDING.—Out of any funds in the  
11          Treasury not otherwise appropriated, there are  
12          appropriated to the Secretary of Health and  
13          Human Services such sums as may be nec-  
14          essary for each of fiscal years 2010 through  
15          2014.

16          (D) LANGUAGE SERVICES.—In this sub-  
17          section, the term “language services” has the  
18          meaning given such term in section 3100 of the  
19          Public Health Service Act.

20          (2) ELIGIBLE COSTS DEFINED.—

21                (A) IN GENERAL.—In this subsection, the  
22                term “eligible costs” means, with respect to an  
23                eligible entity that provides language services to  
24                LEP individuals, the product of—

1 (i) the average per person cost of lan-  
2 guage services, determined according to  
3 the methodology devised under subpara-  
4 graph (B), and

5 (ii) the number of limited English  
6 proficient individuals who are provided lan-  
7 guage services by the entity and for whom  
8 no reimbursement is available for such  
9 services under the amendments made by  
10 subsections (a), (b), or (c) or by private  
11 health insurance.

12 (B) METHODOLOGY.—The Secretary shall  
13 devise a methodology to determine the average  
14 per person cost of language services. In estab-  
15 lishing a payment methodology, the Secretary  
16 may establish different methodologies for dif-  
17 ferent types of eligible entities. The Secretary  
18 shall not require eligible entities to provide indi-  
19 vidual claims for language services for each in-  
20 dividual patient to be provided payment under  
21 this subsection.

22 (3) ELIGIBLE ENTITY.—In order to receive  
23 grants under this paragraph, an entity must—

24 (A) be—

25 (i) an individual provider;

1                   (ii) a hospital with a low income utili-  
2                   zation rate (as defined in section  
3                   1923(b)(3) of the Social Security Act (42  
4                   U.S.C. 1396r-4(b)(3))) of greater than 25  
5                   percent; or

6                   (iii) a Federally-qualified health cen-  
7                   ter (as defined in section 1905(l)(2)(B) of  
8                   the Social Security Act (42 U.S.C.  
9                   1396d(l)(2)(B)));

10                  (B) provide language services to at least 8  
11                  percent of the entity's total number of patients;  
12                  and

13                  (C) prepare and submit an application to  
14                  the Secretary, at such time, in such manner,  
15                  and accompanied by such information as the  
16                  Secretary may require to ascertain the entities'  
17                  eligibility for funding under this subsection.

18                  (4) RELATION TO MEDICAID DSH.—Payments  
19                  under this subsection shall not offset or reduce pay-  
20                  ments under section 1923 of the Social Security Act,  
21                  nor shall payments under such section be considered  
22                  when determining uncompensated costs associated  
23                  with the provision of language services.

24                  (5) REPORTING REQUIREMENTS.—Entities re-  
25                  ceiving payment under this subsection shall provide

1 the Secretary with a quarterly report on such pay-  
2 ments. Such report shall contain aggregate (and not  
3 individualized) data and shall otherwise be in a form  
4 and manner determined by the Secretary. For pur-  
5 poses of this subsection, the Secretary shall create a  
6 standard data collection instrument that is con-  
7 sistent with any existing reporting requirements by  
8 the Secretary or relevant accrediting organizations  
9 regarding the number of individuals to whom lan-  
10 guage access are provided.

11 (6) GUIDANCE.—

12 (A) ESTABLISHMENT.—Not later than 6  
13 months after the date of enactment of this Act,  
14 the Secretary of Health and Human Services  
15 shall establish guidelines concerning the imple-  
16 mentation of this subsection.

17 (B) REPORT.—Not later than 2 years after  
18 the date of enactment of this Act, and every 2  
19 years thereafter, the Secretary shall submit a  
20 report to Congress concerning the implementa-  
21 tion of such guidelines.

22 (e) EFFECTIVE DATE.—The amendments made by  
23 this section take effect on October 1, 2009.

1 **SEC. 103. INCREASING UNDERSTANDING OF AND IMPROV-**  
2 **ING HEALTH LITERACY.**

3 (a) IN GENERAL.—The Secretary, acting through the  
4 Director of the Agency for Healthcare Research and Qual-  
5 ity and the Administrator of the Health Resources and  
6 Services Administration, in consultation with the National  
7 Center on Minority Health and Health Disparities and the  
8 Office of Minority Health, shall award grants to eligible  
9 entities to improve health care for patient populations that  
10 have low functional health literacy.

11 (b) ELIGIBILITY.—To be eligible to receive a grant  
12 under subsection (a), an entity shall—

13 (1) be a hospital, health center or clinic, health  
14 plan, or other health entity (including a nonprofit  
15 minority health organization or association); and

16 (2) prepare and submit to the Secretary an ap-  
17 plication at such time, in such manner, and con-  
18 taining such information as the Secretary may re-  
19 quire.

20 (c) USE OF FUNDS.—

21 (1) AGENCY FOR HEALTHCARE RESEARCH AND  
22 QUALITY.—Grants awarded under subsection (a)  
23 through the Agency for Healthcare Research and  
24 Quality shall be used—

25 (A) to define and increase the under-  
26 standing of health literacy;

1 (B) to investigate the correlation between  
2 low health literacy and health and health care;

3 (C) to clarify which aspects of health lit-  
4 eracy have an effect on health outcomes; and

5 (D) for any other activity determined ap-  
6 propriate by the Director of the Agency.

7 (2) HEALTH RESOURCES AND SERVICES ADMIN-  
8 ISTRATION.—Grants awarded under subsection (a)  
9 through the Health Resources and Services Adminis-  
10 tration shall be used to conduct demonstration  
11 projects for interventions for patients with low  
12 health literacy that may include—

13 (A) the development of new disease man-  
14 agement programs for patients with low health  
15 literacy;

16 (B) the tailoring of existing disease man-  
17 agement programs addressing mental, physical,  
18 oral, and behavioral health conditions for pa-  
19 tients with low health literacy;

20 (C) the translation of written health mate-  
21 rials for patients with low health literacy;

22 (D) the identification, implementation, and  
23 testing of low health literacy screening tools;

1 (E) the conduct of educational campaigns  
2 for patients and providers about low health lit-  
3 eracy; and

4 (F) other activities determined appropriate  
5 by the Administrator of the Health Resources  
6 and Services Administration.

7 (d) DEFINITIONS.—In this section, the term “low  
8 health literacy” means the inability of an individual to ob-  
9 tain, process, and understand basic health information  
10 and services needed to make appropriate health decisions.

11 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
12 are authorized to be appropriated to carry out this section,  
13 such sums as may be necessary for each of fiscal years  
14 2010 through 2014.

15 **SEC. 104. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

16 (a) IN GENERAL.—Entities that receive Federal  
17 funds under sections 101 or 102 (including under the  
18 amendments made by such section), in order to ensure the  
19 right of LEP individuals to receive access to quality health  
20 care, shall—

21 (1) ensure that appropriate clinical and support  
22 staff receive ongoing education and training in lin-  
23 guistically appropriate service delivery;

24 (2) offer and provide appropriate language serv-  
25 ices at no additional charge to each patient with lim-

1       ited English proficiency at all points of contact, in  
2       a timely manner during all hours of operation;

3               (3) notify patients of their right to receive lan-  
4       guage services in their primary language; and

5               (4) utilize only competent interpreter or trans-  
6       lation services which—

7                       (A) until adoption of the Interpreter and  
8       Translator Guidelines and Standards described  
9       in section 3103(c) of the Public Health Service  
10      Act, are defined in section 3100 of the Public  
11      Health Service Act; and

12                      (B) after adoption of the Interpreter and  
13      Translator Guidelines and Standards described  
14      in section 3103(c) of the Public Health Service  
15      Act, meet those guidelines and standards;

16      (b) EXEMPTIONS.—The requirements of subsection  
17   (a)(4) shall not apply as follows:

18               (1) When a patient (who has been informed in  
19      his or her primary language of the availability of  
20      free interpreter and translation services) requests  
21      the use of family, friends or other persons untrained  
22      in interpretation or translation if the following con-  
23      ditions are met:

24                      (A) The interpreter requested by the pa-  
25      tient is over the age of 18.



1           (B) The recipient informs the patient that  
2           he or she has the option of having the recipient  
3           provide an interpreter for him/her without  
4           charge, or of using his/her own interpreter.

5           (C) The recipient informs the patient that  
6           the recipient may not require an LEP person to  
7           use a family member or friend as an inter-  
8           preter.

9           (D) The recipient evaluates whether the  
10          person the patient wishes to use as an inter-  
11          preter is competent. If the recipient has reason  
12          to believe that the interpreter is not competent,  
13          the recipient provides its own interpreter to  
14          protect the recipient from liability if the pa-  
15          tient's interpreter is later found not competent.

16          (E) If the recipient has reason to believe  
17          that there is a conflict of interest between the  
18          interpreter and patient, the recipient may not  
19          use the patient's interpreter.

20          (F) The recipient has the patient sign a  
21          waiver, witnessed by at least one individual not  
22          related to the patient, that includes the infor-  
23          mation stated in subparagraphs (A) through  
24          (E) and is translated into the patient's lan-  
25          guage.

1           (2) When a medical emergency exists and the  
2       delay directly associated with obtaining competent  
3       interpreter or translation services would jeopardize  
4       the health of the patient but only until a competent  
5       interpreter or translation service is available; how-  
6       ever, nothing in this subsection shall exempt emer-  
7       gency rooms or similar entities that regularly pro-  
8       vide health care services in medical emergencies  
9       from having in place systems to provide competent  
10      interpreter and translation services without undue  
11      delay.

12 **SEC. 105. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**  
13 **TURALLY AND LINGUISTICALLY APPRO-**  
14 **PRIATE HEALTH CARE SERVICES.**

15       (a) REPORT.—Not later than 1 year after the date  
16 of enactment of this Act and annually thereafter, the Sec-  
17 retary of Health and Human Services shall enter into a  
18 contract with the Institute of Medicine for the preparation  
19 and publication of a report that describes Federal efforts  
20 to ensure that all individuals with limited English pro-  
21 ficiency have meaningful access to health care and health  
22 care-related services. Such report shall include—

23           (1) a description and evaluation of the activities  
24       carried out under this Act;

1           (2) a description and analysis of best practices,  
 2       model programs, guidelines, and other effective  
 3       strategies for providing access to culturally and lin-  
 4       guistically appropriate health care services;

5           (3) recommendations on the development and  
 6       implementation of policies and practices by providers  
 7       of health care and health care-related services for  
 8       limited English proficient individuals;

9           (4) a description of the effect of providing lan-  
 10      guage services on quality of health care and access  
 11      to care; and

12          (5) a description of the costs associated with or  
 13      savings related to the provision of language services.

14       (b) AUTHORIZATION OF APPROPRIATIONS.—There  
 15   are authorized to be appropriated to carry out this section  
 16   such sums as may be necessary for each of fiscal years  
 17   2010 through 2014.

18   **SEC. 106. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

19       (a) GRANTS AUTHORIZED.—The Secretary of Edu-  
 20   cation is authorized to provide grants to States for the  
 21   provision of English as a second language (hereafter re-  
 22   ferred to as “ESL”) instruction and shall determine, after  
 23   consultation with appropriate stakeholders, the mecha-  
 24   nism for administering and distributing such grants.

1       (b) APPLICATION.—A State may apply for a grant  
2 under this section by submitting such information as the  
3 Secretary may require and in such form and manner as  
4 the Secretary may require.

5       (c) USE OF GRANT.—As a condition of receiving a  
6 grant under this section, a State shall—

7           (1) develop and implement a plan for assuring  
8 the availability of ESL instruction that effectively  
9 integrates information about the nature of the  
10 United States health care system, how to access  
11 care, and any special language skills that may be re-  
12 quired for them to access and regularly negotiate the  
13 system effectively;

14          (2) develop a plan, including, where appro-  
15 priate, public-private partnerships, for making ESL  
16 instruction progressively available to all individuals  
17 seeking instruction; and

18          (3) maintain current ESL instruction efforts by  
19 using the additional funds to supplement rather  
20 than supplant any funds expended for ESL instruc-  
21 tion in the State as of January 1, 2006.

22       (d) ADDITIONAL DUTIES OF THE SECRETARY.—The  
23 Secretary of Education shall—

1           (1) collect and publicize annual data on how  
2           much Federal, State, and local governments spend  
3           on ESL instruction;

4           (2) collect data from state and local govern-  
5           ments to identify the unmet needs of English lan-  
6           guage learners for appropriate ESL instruction, in-  
7           cluding—

8                   (A) the extent of waiting lists including  
9                   how many programs maintain waiting lists and,  
10                  for programs that do not have waiting lists, the  
11                  reasons why not;

12                  (B) the availability of programs to geo-  
13                  graphically isolated communities;

14                  (C) the impact of course enrollment poli-  
15                  cies, including open enrollment, on the avail-  
16                  ability of ESL instruction;

17                  (D) the number individuals in the State  
18                  and each participating locality;

19                  (E) the effectiveness of the instruction in  
20                  meeting the needs of individuals receiving in-  
21                  struction and those needing instruction;

22                  (F) as assessment of the need for pro-  
23                  grams that integrate job training and ESL in-  
24                  struction, to assist individuals to obtain better  
25                  jobs; and

1 (G) the availability of ESL slots by State  
2 and locality;

3 (3) determine the cost and most appropriate  
4 methods of making ESL instruction available to all  
5 English language learners seeking instruction; and

6 (4) within 1 year of the date of enactment of  
7 this Act, issue a report to Congress that assesses the  
8 information collected in subparagraphs (1), (2), and  
9 (3) and makes recommendations on steps that  
10 should be taken to progressively realize the goal of  
11 making ESL instruction available to all English lan-  
12 guage learners seeking instruction.

13 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
14 are authorized to be appropriated to the Secretary of Edu-  
15 cation for each of fiscal years 2010 through 2013  
16 \$250,000,000 to carry out this section.

17 **SEC. 107. DEFINITION.**

18 In this title, the definitions contained in section 3100  
19 of the Public Health Service Act, as added by section 101,  
20 shall apply.

21 **SEC. 108. TREATMENT OF THE MEDICARE PART B PRO-**  
22 **GRAM UNDER TITLE VI OF THE CIVIL RIGHTS**  
23 **ACT OF 1964.**

24 A payment to a provider of services, physician, or  
25 other supplier under part B, C, or D of title XVIII of

1 the Social Security Act shall be deemed a grant, and not  
2 a contract of insurance or guaranty, for the purposes of  
3 title VI of the Civil Rights Act of 1964.

4 **SEC. 109. IMPLEMENTATION.**

5 (a) GENERAL PROVISIONS.—

6 (1) A State shall not be immune under the  
7 Eleventh Amendment of the Constitution of the  
8 United States from suit in Federal court for failing  
9 to provide the language access funded pursuant to  
10 this Act.

11 (2) In a suit against a State for a violation of  
12 this Act, remedies (including remedies at both at law  
13 and in equity) are available for such a violation to  
14 the same extent as such remedies are available for  
15 such a violation in the suit against any public or pri-  
16 vate entity other than a State.

17 (b) RULE OF CONSTRUCTION.—Nothing in this Act  
18 shall be construed to limit otherwise existing obligations  
19 of recipients of Federal financial assistance under title VI  
20 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et  
21 seq.) or any other statute.

1   **TITLE II—HEALTH WORKFORCE**  
2                   **DIVERSITY**

3   **SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
4                   **ACT.**

5           Title XXXI of the Public Health Service Act, as  
6 added by section 201, is amended by adding at the end  
7 the following:

8           **“Subtitle A—Diversifying the**  
9                   **Healthcare Workplace**

10   **“SEC. 3111. REPORT ON WORKFORCE DIVERSITY.**

11           “(a) IN GENERAL.—Not later than July 1, 2010, and  
12 biannually thereafter, the Secretary, acting through the  
13 director of each entity within the Department of Health  
14 and Human Services, shall prepare and submit to the  
15 Committee on Health, Education, Labor, and Pensions of  
16 the Senate and the Committee on Energy and Commerce  
17 of the House of Representatives a report on health work-  
18 force diversity.

19           “(b) REQUIREMENT.—The report under subsection  
20 (a) shall contain the following information:

21                   “(1) A description of any grant support that is  
22 provided by each entity for workforce diversity ini-  
23 tiatives with the following information—

24                           “(A) the number of grants made;

25                           “(B) the purpose of the grants;



1           “(C) the populations served through the  
2           grants;

3           “(D) the organizations and institutions re-  
4           ceiving the grants; and

5           “(E) the tracking efforts that were used to  
6           follow the progress of participants.

7           “(2) A description of the entity’s plan to  
8           achieve workforce diversity goals that includes, to  
9           the extent relevant to such entity—

10           “(A) the number of underrepresented mi-  
11           nority health professionals that will be needed  
12           in various disciplines over the next 10 years to  
13           achieve population parity;

14           “(B) the level of funding needed to fully  
15           expand and adequately support health profes-  
16           sions pipeline programs;

17           “(C) the impact such programs have had  
18           on the admissions practices and policies of  
19           health professions schools;

20           “(D) the management strategy necessary  
21           to effectively administer and institutionalize  
22           health profession pipeline programs; and

23           “(E) the impact that the Government Per-  
24           formance and Results Act (GPRA) has had on  
25           evaluating the performance of grantees and

1           whether the GPRA is the best assessment tool  
2           for programs under titles VII and VIII.

3           “(3) A description of measurable objectives of  
4           each entity relating to workforce diversity initiatives.

5           “(c) PUBLIC AVAILABILITY.—The report under sub-  
6           section (a) shall be made available for public review and  
7           comment.

8           **“SEC. 3112. NATIONAL WORKING GROUP ON WORKFORCE**  
9                           **DIVERSITY.**

10          “(a) IN GENERAL.—The Secretary, acting through  
11          the Bureau of Health Professions within the Health Re-  
12          sources and Services Administration, shall award a grant  
13          to an entity determined appropriate by the Secretary for  
14          the establishment of a national working group on work-  
15          force diversity.

16          “(b) REPRESENTATION.—In establishing the national  
17          working group under subsection (a), the grantee shall en-  
18          sure that the group has representation from the following  
19          entities:

20                 “(1) The Health Resources and Services Ad-  
21                 ministration.

22                 “(2) The Department of Health and Human  
23                 Services Data Council.

24                 “(3) The Office of Minority Health.

1           “(4) The Bureau of Labor Statistics of the De-  
2       partment of Labor.

3           “(5) The Public Health Practice Program Of-  
4       fice—Office of Workforce Policy and Planning.

5           “(6) The National Center on Minority Health  
6       and Health Disparities.

7           “(7) The Agency for Healthcare Research and  
8       Quality.

9           “(8) The Institute of Medicine Study Com-  
10      mittee for the 2004 workforce diversity report.

11          “(9) The Indian Health Service.

12          “(10) Academic institutions.

13          “(11) Consumer organizations.

14          “(12) Health professional associations, includ-  
15      ing those that represent underrepresented minority  
16      populations.

17          “(13) Researchers in the area of health work-  
18      force.

19          “(14) Health workforce accreditation entities.

20          “(15) Private foundations that have sponsored  
21      workforce diversity initiatives.

22          “(16) Not less than 5 health professions stu-  
23      dents representing various health profession fields  
24      and levels of training.

1       “(c) ACTIVITIES.—The working group established  
2 under subsection (a) shall convene at least twice each year  
3 to complete the following activities:

4           “(1) Review current public and private health  
5 workforce diversity initiatives.

6           “(2) Identify successful health workforce diver-  
7 sity programs and practices.

8           “(3) Examine challenges relating to the devel-  
9 opment and implementation of health workforce di-  
10 versity initiatives.

11          “(4) Draft a national strategic work plan for  
12 health workforce diversity, including recommenda-  
13 tions for public and private sector initiatives.

14          “(5) Develop a framework and methods for the  
15 evaluation of current and future health workforce di-  
16 versity initiatives.

17          “(6) Develop recommended standards for work-  
18 force diversity that could be applicable to all health  
19 professions programs and programs funded under  
20 this Act.

21          “(7) Develop curriculum guidelines for diversity  
22 training.

23          “(8) Develop a strategy for the inclusion of  
24 community members on admissions committees for  
25 health profession schools.

1           “(9) Other activities determined appropriate by  
2       the Secretary.

3           “(d) ANNUAL REPORT.—Not later than 1 year after  
4       the establishment of the working group under subsection  
5       (a), and annually thereafter, the working group shall pre-  
6       pare and make available to the general public for com-  
7       ment, an annual report on the activities of the working  
8       group. Such report shall include the recommendations of  
9       the working group for improving health workforce diver-  
10      sity.

11          “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
12      is authorized to be appropriated to carry out this section,  
13      such sums as may be necessary for each of fiscal years  
14      2010 through 2015.

15      **“SEC. 3113. TECHNICAL CLEARINGHOUSE FOR HEALTH**  
16                                      **WORKFORCE DIVERSITY.**

17          “(a) IN GENERAL.—The Secretary, acting through  
18      the Office of Minority Health, and in collaboration with  
19      the Bureau of Health Professions within the Health Re-  
20      sources and Services Administration, the National Center  
21      on Minority Health and Health Disparities, shall establish  
22      a technical clearinghouse on health workforce diversity  
23      within the Office of Minority Health and coordinate cur-  
24      rent and future clearinghouses.

1       “(b) INFORMATION AND SERVICES.—The clearing-  
2 house established under subsection (a) shall offer the fol-  
3 lowing information and services:

4           “(1) Information on the importance of health  
5 workforce diversity.

6           “(2) Statistical information relating to under-  
7 represented minority representation in health and al-  
8 lied health professions and occupations.

9           “(3) Model health workforce diversity practices  
10 and programs.

11          “(4) Admissions policies that promote health  
12 workforce diversity and are in compliance with Fed-  
13 eral and State laws.

14          “(5) Lists of scholarship, loan repayment, and  
15 loan cancellation grants as well as fellowship infor-  
16 mation for underserved populations for health pro-  
17 fessions schools.

18          “(6) Foundation and other large organizational  
19 initiatives relating to health workforce diversity.

20       “(c) CONSULTATION.—In carrying out this section,  
21 the Secretary shall consult with non-Federal entities which  
22 may include minority health professional associations to  
23 ensure the adequacy and accuracy of information.

24       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
25 is authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years  
2 2010 through 2015.

3 **“SEC. 3114. EVALUATION OF WORKFORCE DIVERSITY INI-**  
4 **TIATIVES.**

5 “(a) IN GENERAL.—The Secretary, acting through  
6 the Bureau of Health Professions within the Health Re-  
7 sources and Services Administration, shall award grants  
8 to eligible entities for the conduct of an evaluation of cur-  
9 rent health workforce diversity initiatives funded by the  
10 Department of Health and Human Services.

11 “(b) ELIGIBILITY.—To be eligible to receive a grant  
12 under subsection (a) an entity shall—

13 “(1) be a city, county, Indian tribe, State, terri-  
14 tory, community-based nonprofit organization,  
15 health center, university, college, or other entity de-  
16 termined appropriate by the Secretary;

17 “(2) with respect to an entity that is not an  
18 academic medical center, university, or private re-  
19 search institution, carry out activities under the  
20 grant in partnership with an academic medical cen-  
21 ter, university, or private research institution; and

22 “(3) submit to the Secretary an application at  
23 such time, in such manner, and containing such in-  
24 formation as the Secretary may require.

1       “(c) USE OF FUNDS.—Amounts awarded under a  
2 grant under subsection (a) shall be used to support the  
3 following evaluation activities:

4           “(1) Determinations of measures of health  
5 workforce diversity success.

6           “(2) The short- and long-term tracking of par-  
7 ticipants in health workforce diversity pipeline pro-  
8 grams funded by the Department of Health and  
9 Human Services.

10          “(3) Assessments of partnerships formed  
11 through activities to increase health workforce diver-  
12 sity.

13          “(4) Assessments of barriers to health work-  
14 force diversity.

15          “(5) Assessments of policy changes at the Fed-  
16 eral, State, and local levels.

17          “(6) Assessments of coordination within and be-  
18 tween Federal agencies and other institutions.

19          “(7) Other activities determined appropriate by  
20 the Secretary and the Working Group established  
21 under section 3112.

22       “(d) REPORT.—Not later than 1 year after the date  
23 of enactment of this title, the Bureau of Health Profes-  
24 sions within the Health Resources and Services Adminis-  
25 tration shall prepare and make available for public com-



1 ment a report that summarizes the findings made by enti-  
 2 ties under grants under this section.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
 4 is authorized to be appropriated to carry out this section,  
 5 such sums as may be necessary for each of fiscal years  
 6 2010 through 2015.

7 **“SEC. 3115. DATA COLLECTION AND REPORTING BY**  
 8 **HEALTH PROFESSIONAL SCHOOLS.**

9 “(a) IN GENERAL.—The Secretary, acting through  
 10 the Bureau of Health Professions of the Health Resources  
 11 and Services Administration and the Office of Minority  
 12 Health, shall establish an aggregated database on health  
 13 professional students.

14 “(b) REQUIREMENT TO COLLECT DATA.—Each  
 15 health professional school (including medical, dental, and  
 16 nursing schools) and allied health profession school and  
 17 program that receives Federal funds shall collect race, eth-  
 18 nicity, and language proficiency data concerning those stu-  
 19 dents enrolled at such schools or in such programs. In col-  
 20 lecting such data, a school or program shall—

21 “(1) at a minimum, use the categories for race  
 22 and ethnicity described in the 1997 Office of Man-  
 23 agement and Budget Standards for Maintaining,  
 24 Collecting, and Presenting Federal Data on Race  
 25 and Ethnicity and available language standards; and

1           “(2) if practicable, collect data on additional  
2           population groups if such data can be aggregated  
3           into the minimum race and ethnicity data categories.

4           “(c) USE OF DATA.—Data on race, ethnicity, pri-  
5           mary language, gender, and sexual orientation collected  
6           under this section shall be reported to the database estab-  
7           lished under subsection (a) on an annual basis. Such data  
8           shall be available for public use.

9           “(d) PRIVACY.—The Secretary shall ensure that all  
10          data collected under this section is protected from inap-  
11          propriate internal and external use by any entity that col-  
12          lects, stores, or receives the data and that such data is  
13          collected without personally identifiable information.

14          “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
15          is authorized to be appropriated to carry out this section,  
16          such sums as may be necessary for each of fiscal years  
17          2010 through 2015.

18       **“SEC. 3116. SUPPORT FOR INSTITUTIONS COMMITTED TO**  
19               **WORKFORCE DIVERSITY.**

20          “(a) IN GENERAL.—The Secretary, acting through  
21          the Administrator of the Health Resources and Services  
22          Administration, shall award grants to eligible entities that  
23          demonstrate a commitment to health workforce diversity.

24          “(b) ELIGIBILITY.—To be eligible to receive a grant  
25          under subsection (a), an entity shall—

1           “(1) be an educational institution or entity that  
2           historically produces or trains meaningful numbers  
3           of underrepresented minority health professionals,  
4           including—

5                   “(A) Historically Black Colleges and Uni-  
6                   versities;

7                   “(B) Hispanic-Serving Health Professions  
8                   Schools;

9                   “(C) Hispanic-Serving Institutions;

10                  “(D) Tribal Colleges and Universities;

11                  “(E) Asian American and Pacific Islander-  
12                  serving institutions;

13                  “(F) institutions that have programs to re-  
14                  cruit and retain underrepresented minority  
15                  health professionals, in which a significant  
16                  number of the enrolled participants are under-  
17                  represented minorities;

18                  “(G) health professional associations,  
19                  which may include underrepresented minority  
20                  health professional associations; and

21                  “(H) institutions—

22                          “(i) located in communities with pre-  
23                          dominantly underrepresented minority pop-  
24                          ulations;

1                   “(ii) with whom partnerships have  
2                   been formed for the purpose of increasing  
3                   workforce diversity; and

4                   “(iii) in which at least 20 percent of  
5                   the enrolled participants are underrep-  
6                   resented minorities; and

7                   “(2) submit to the Secretary an application at  
8                   such time, in such manner, and containing such in-  
9                   formation as the Secretary may require.

10                  “(c) USE OF FUNDS.—Amounts received under a  
11                  grant under subsection (a) shall be used to expand existing  
12                  workforce diversity programs, implement new workforce  
13                  diversity programs, or evaluate existing or new workforce  
14                  diversity programs, including with respect to mental  
15                  health care professions. Such programs shall enhance di-  
16                  versity by considering minority status as part of an indi-  
17                  vidualized consideration of qualifications. Possible activi-  
18                  ties may include—

19                       “(1) educational outreach programs relating to  
20                       opportunities in the health professions;

21                       “(2) scholarship, fellowship, grant, loan repay-  
22                       ment, and loan cancellation programs;

23                       “(3) post-baccalaureate programs;

1           “(4) academic enrichment programs, particu-  
2           larly targeting those who would not be competitive  
3           for health professions schools;

4           “(5) kindergarten through 12th grade and  
5           other health pipeline programs;

6           “(6) mentoring programs;

7           “(7) internship or rotation programs involving  
8           hospitals, health systems, health plans and other  
9           health entities;

10          “(8) community partnership development for  
11          purposes relating to workforce diversity; or

12          “(9) leadership training.

13          “(d) REPORTS.—Not later than 1 year after receiving  
14 a grant under this section, and annually for the term of  
15 the grant, a grantee shall submit to the Secretary a report  
16 that summarizes and evaluates all activities conducted  
17 under the grant.

18          “(e) DEFINITION.—In this section, the term ‘Asian  
19 American and Pacific Islander-serving institutions’ means  
20 institutions—

21           “(1) that are eligible institutions under section  
22 312(b) of the Higher Education Act of 1965; and

23           “(2) that, at the time of their application, have  
24 an enrollment of undergraduate students that is

1       made up of at least 10 percent Asian American and  
2       Pacific Islander students.

3       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
4 is authorized to be appropriated to carry out this section,  
5 such sums as may be necessary for each of fiscal years  
6 2010 through 2015.

7       **“SEC. 3117. CAREER DEVELOPMENT FOR SCIENTISTS AND**  
8                   **RESEARCHERS.**

9       “(a) IN GENERAL.—The Secretary, acting through  
10 the Director of the National Institutes of Health, the Di-  
11 rector of the Centers for Disease Control and Prevention,  
12 the Commissioner of Food and Drugs, and the Director  
13 of the Agency for Healthcare Research and Quality, shall  
14 award grants that expand existing opportunities for sci-  
15 entists and researchers and promote the inclusion of  
16 underrepresented minorities in the health professions.

17       “(b) RESEARCH FUNDING.—The head of each entity  
18 within the Department of Health and Human Services  
19 shall establish or expand existing programs to provide re-  
20 search funding to scientists and researchers in-training.  
21 Under such programs, the head of each such entity shall  
22 give priority in allocating research funding to support  
23 health research in traditionally underserved communities,  
24 including underrepresented minority communities, and re-  
25 search classified as community or participatory.

1       “(c) DATA COLLECTION.—The head of each entity  
2 within the Department of Health and Human Services  
3 shall collect data on the number (expressed as an absolute  
4 number and a percentage) of underrepresented minority  
5 and nonminority applicants who receive and are denied  
6 agency funding at every stage of review. Such data shall  
7 be reported annually to the Secretary and the appropriate  
8 committees of Congress.

9       “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-  
10 retary shall establish a student loan reimbursement pro-  
11 gram to provide student loan reimbursement assistance to  
12 researchers who focus on racial and ethnic disparities in  
13 health. The Secretary shall promulgate regulations to de-  
14 fine the scope and procedures for the program under this  
15 subsection.

16       “(e) STUDENT LOAN CANCELLATION.—The Sec-  
17 retary shall establish a student loan cancellation program  
18 to provide student loan cancellation assistance to research-  
19 ers who focus on racial and ethnic disparities in health.  
20 Students participating in the program shall make a min-  
21 imum 5-year commitment to work at an accredited health  
22 profession school. The Secretary shall promulgate addi-  
23 tional regulations to define the scope and procedures for  
24 the program under this subsection.

1       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
2 is authorized to be appropriated to carry out this section,  
3 such sums as may be necessary for each of fiscal years  
4 2010 through 2015.

5       **“SEC. 3118. CAREER SUPPORT FOR NON-RESEARCH**  
6                   **HEALTH PROFESSIONALS.**

7       “(a) IN GENERAL.—The Secretary, acting through  
8 the Director of the Centers for Disease Control and Pre-  
9 vention, the Administrator of the Substance Abuse and  
10 Mental Health Services Administration, the Administrator  
11 of the Health Resources and Services Administration, and  
12 the Administrator of the Centers for Medicare and Med-  
13 icaid Services shall establish a program to award grants  
14 to eligible individuals for career support in non-research-  
15 related healthcare.

16       “(b) ELIGIBILITY.—To be eligible to receive a grant  
17 under subsection (a) an individual shall—

18               “(1) be a student in a health professions school,  
19 a graduate of such a school who is working in a  
20 health profession, or a faculty member of such a  
21 school; and

22               “(2) submit to the Secretary an application at  
23 such time, in such manner, and containing such in-  
24 formation as the Secretary may require.



1       “(c) USE OF FUNDS.—An individual shall use  
2 amounts received under a grant under this section to—

3               “(1) support the individual’s health activities or  
4 projects that involve underserved communities, in-  
5 cluding racial and ethnic minority communities;

6               “(2) support health-related career advancement  
7 activities; and

8               “(3) to pay, or as reimbursement for payments  
9 of, student loans for individuals who are health pro-  
10 fessionals and are focused on health issues affecting  
11 underserved communities, including racial and eth-  
12 nic minority communities.

13       “(d) DEFINITION.—In this section, the term ‘career  
14 in non-research-related healthcare’ means employment or  
15 intended employment in the field of public health, health  
16 policy, health management, health administration, medi-  
17 cine, nursing, pharmacy, allied health, community health,  
18 or other fields determined appropriate by the Secretary,  
19 other than in a position that involves research.

20       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
21 is authorized to be appropriated to carry out this section,  
22 such sums as may be necessary for each of fiscal years  
23 2010 through 2015.

1   **“SEC. 3119. RESEARCH ON THE EFFECT OF WORKFORCE DI-**  
2                   **VERSITY ON QUALITY.**

3           “(a) IN GENERAL.—The Director of the Agency for  
4   Healthcare Research and Quality, in collaboration with  
5   the Director of the Office of Minority Health and the Di-  
6   rector of the National Center on Minority Health and  
7   Health Disparities, shall award grants to eligible entities  
8   to expand research on the link between health workforce  
9   diversity and quality healthcare.

10          “(b) ELIGIBILITY.—To be eligible to receive a grant  
11   under subsection (a) an entity shall—

12               “(1) be a clinical, public health, or health serv-  
13   ices research entity or other entity determined ap-  
14   propriate by the Director; and

15               “(2) submit to the Secretary an application at  
16   such time, in such manner, and containing such in-  
17   formation as the Secretary may require.

18          “(c) USE OF FUNDS.—Amounts received under a  
19   grant awarded under subsection (a) shall be used to sup-  
20   port research that investigates the effect of health work-  
21   force diversity on—

22               “(1) language access;

23               “(2) cultural competence;

24               “(3) patient satisfaction;

25               “(4) timeliness of care;

26               “(5) safety of care;

- 1 “(6) effectiveness of care;
- 2 “(7) efficiency of care;
- 3 “(8) patient outcomes;
- 4 “(9) community engagement;
- 5 “(10) resource allocation;
- 6 “(11) organizational structure;
- 7 “(12) other topics determined appropriate by
- 8 the Director; or
- 9 “(13) compliance of care.

10 “(d) PRIORITY.—In awarding grants under sub-  
 11 section (a), the Director shall give individualized consider-  
 12 ation to all relevant aspects of the applicant’s background.  
 13 Consideration of prior research experience involving the  
 14 health of underserved communities shall be such a factor.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
 16 is authorized to be appropriated to carry out this section,  
 17 such sums as may be necessary for each of fiscal years  
 18 2010 through 2015.

19 **“SEC. 3120. HEALTH DISPARITIES EDUCATION PROGRAM.**

20 “(a) ESTABLISHMENT.—The Secretary, acting  
 21 through the National Center on Minority Health and  
 22 Health Disparities and in collaboration with the Office of  
 23 Minority Health, the Office for Civil Rights, the Centers  
 24 for Disease Control and Prevention, the Centers for Medi-  
 25 care and Medicaid Services, the Health Resources and

1 Services Administration, and other appropriate public and  
2 private entities, shall establish and coordinate a health and  
3 healthcare disparities education program to support, de-  
4 velop, and implement educational initiatives and outreach  
5 strategies that inform healthcare professionals and the  
6 public about the existence of and methods to reduce racial  
7 and ethnic disparities in health and healthcare.

8 “(b) ACTIVITIES.—The Secretary, through the edu-  
9 cation program established under subsection (a) shall,  
10 through the use of public awareness and outreach cam-  
11 paigns targeting the general public and the medical com-  
12 munity at large—

13 “(1) disseminate scientific evidence for the ex-  
14 istence and extent of racial and ethnic disparities in  
15 healthcare, including disparities that are not other-  
16 wise attributable to known factors such as access to  
17 care, patient preferences, or appropriateness of  
18 intervention, as described in the 2002 Institute of  
19 Medicine Report, Unequal Treatment;

20 “(2) disseminate new research findings to  
21 healthcare providers and patients to assist them in  
22 understanding, reducing, and eliminating health and  
23 healthcare disparities;

24 “(3) disseminate information about the impact  
25 of linguistic and cultural barriers on healthcare qual-

1       ity and the obligation of health providers who receive  
2       Federal financial assistance to ensure that people  
3       with limited English proficiency have access to lan-  
4       guage access services;

5           “(4) disseminate information about the impor-  
6       tance and legality of racial, ethnic, and primary lan-  
7       guage data collection, analysis, and reporting;

8           “(5) design and implement specific educational  
9       initiatives to health care providers relating to health  
10      and health care disparities; and

11          “(6) assess the impact of the programs estab-  
12      lished under this section in raising awareness of  
13      health and healthcare disparities and providing in-  
14      formation on available resources.

15      “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
16      is authorized to be appropriated to carry out this section,  
17      such sums as may be necessary for each of fiscal years  
18      2010 through 2015.

19      **“SEC. 3120A. CULTURAL COMPETENCE TRAINING FOR**  
20                   **HEALTHCARE PROFESSIONALS.**

21          “(a) IN GENERAL.—The Secretary, acting through  
22      the Administrator of the Health Resources and Services  
23      Administration, the Director of the Office of Minority  
24      Health, and the Director of the National Center for Mi-  
25      nority Health and Health Disparities, shall award grants

1 to eligible entities to test, implement, and evaluate models  
2 of cultural competence training, including continuing edu-  
3 cation, for healthcare providers in coordination with the  
4 initiative under section 3120(a).

5 “(b) ELIGIBILITY.—To be eligible to receive a grant  
6 under subsection (a), an entity shall—

7 “(1) be an academic medical center, a health  
8 center or clinic, a hospital, a health plan, a health  
9 system, or a health care professional guild (including  
10 a mental health care professional guild);

11 “(2) partner with a minority serving institution,  
12 minority professional association, or community-  
13 based organization representing minority popu-  
14 lations, in addition to a research institution to carry  
15 out activities under this grant; and

16 “(3) prepare and submit to the Secretary an  
17 application at such time, in such manner, and con-  
18 taining such information as the Secretary may re-  
19 quire.

20 “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
21 is authorized to be appropriated to carry out this section,  
22 such sums as may be necessary for each of fiscal years  
23 2010 through 2015.”.

1 **SEC. 202. HEALTH CAREERS OPPORTUNITY PROGRAM.**

2 (a) PURPOSE.—It is the purpose of this section to  
3 diversify the healthcare workforce by increasing the num-  
4 ber of individuals from disadvantaged backgrounds in the  
5 health and allied health professions by enhancing the aca-  
6 demic skills of students from disadvantaged backgrounds  
7 and supporting them in successfully competing, entering,  
8 and graduating from health professions training pro-  
9 grams.

10 (b) AUTHORIZATION OF APPROPRIATIONS.—Section  
11 740(c) of the Public Health Service Act (42 U.S.C.  
12 293d(c)) is amended by striking “\$29,400,000” and all  
13 that follows through “2002” and inserting “\$50,000,000  
14 for fiscal year 2010, and such sums as may be necessary  
15 for each of fiscal years 2011 through 2015”.

16 **SEC. 203. PROGRAM OF EXCELLENCE IN HEALTH PROFES-**  
17 **SIONS EDUCATION FOR UNDERREP-**  
18 **RESENTED MINORITIES.**

19 (a) PURPOSE.—It is the purpose of this section to  
20 diversify the healthcare workforce by supporting programs  
21 of excellence in designated health professions schools that  
22 demonstrate a commitment to underrepresented minority  
23 populations with a focus on minority health issues, cul-  
24 tural and linguistic competence, and eliminating health  
25 disparities.

1 (b) AUTHORIZATION OF APPROPRIATION.—Section  
2 736(h)(1) of the Public Health Service Act (42 U.S.C.  
3 293(h)(1)) is amended to read as follows:

4 “(1) AUTHORIZATION OF APPROPRIATIONS.—  
5 For the purpose of making grants under subsection  
6 (a), there are authorized to be appropriated  
7 \$50,000,000 for fiscal year 2010, and such sums as  
8 may be necessary for each of the fiscal years 2011  
9 through 2015.”.

10 **SEC. 204. HISPANIC-SERVING HEALTH PROFESSIONS**  
11 **SCHOOLS.**

12 Part B of title VII of the Public Health Service Act  
13 (42 U.S.C. 293 et seq.) is amended by adding at the end  
14 the following:

15 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**  
16 **SCHOOLS.**

17 “(a) IN GENERAL.—The Secretary, acting through  
18 the Administrator of the Health Resources and Services  
19 Administration, shall award grants to Hispanic-serving  
20 health professions schools for the purpose of carrying out  
21 programs to recruit Hispanic individuals to enroll in and  
22 graduate from such schools, which may include providing  
23 scholarships and other financial assistance as appropriate.



1 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-  
 2 panic-serving health professions school’ means an entity  
 3 that—

4 “(1) is a school or program under section  
 5 799B;

6 “(2) has an enrollment of full-time equivalent  
 7 students that is made up of at least 9 percent His-  
 8 panic students;

9 “(3) has been effective in carrying out pro-  
 10 grams to recruit Hispanic individuals to enroll in  
 11 and graduate from the school;

12 “(4) has been effective in recruiting and retain-  
 13 ing Hispanic faculty members; and

14 “(5) has a significant number of graduates who  
 15 are providing health services to medically under-  
 16 served populations or to individuals in health profes-  
 17 sional shortage areas.”.

18 **SEC. 205. HEALTH PROFESSIONS STUDENT LOAN FUND; AU-**  
 19 **THORIZATIONS OF APPROPRIATIONS RE-**  
 20 **GARDING STUDENTS FROM DISADVANTAGED**  
 21 **BACKGROUNDS.**

22 Section 724(f)(1) of the Public Health Service Act  
 23 (42 U.S.C. 292t(f)(1)) is amended by striking  
 24 “\$8,000,000” and all that follows and inserting  
 25 “\$35,000,000 for fiscal year 2010, and such sums as may

1 be necessary for each of the fiscal years 2011 through  
2 2015.”.

3 **SEC. 206. NATIONAL HEALTH SERVICE CORPS; RECRUIT-**  
4 **MENT AND FELLOWSHIPS FOR INDIVIDUALS**  
5 **FROM DISADVANTAGED BACKGROUNDS.**

6 (a) IN GENERAL.—Section 331(b) of the Public  
7 Health Service Act (42 U.S.C. 254d(b)) is amended by  
8 adding at the end the following:

9 “(3) The Secretary shall ensure that the individuals  
10 with respect to whom activities under paragraphs (1) and  
11 (2) are carried out include individuals from disadvantaged  
12 backgrounds, including activities carried out to provide  
13 health professions students with information on the Schol-  
14 arship and Repayment Programs.”.

15 (b) ASSIGNMENT OF CORPS PERSONNEL.—Section  
16 333(a) of the Public Health Service Act (42 U.S.C.  
17 254f(a)) is amended by adding at the end the following:

18 “(4) In assigning Corps personnel under this section,  
19 the Secretary shall give preference to applicants who re-  
20 quest assignment to a Federally-qualified health center (as  
21 defined in section 1905(l)(2)(B) of the Social Security  
22 Act) or to a provider organization that has a majority of  
23 patients who are minorities or individuals from low-income  
24 families (families with a family income that is less than  
25 200 percent of the Official Poverty Line).”.

1 **SEC. 207. LOAN REPAYMENT PROGRAM OF CENTERS FOR**  
2 **DISEASE CONTROL AND PREVENTION.**

3 Section 317F(c) of the Public Health Service Act (42  
4 U.S.C. 247b–7(c)) is amended—

5 (1) by striking “and” after “1994,”; and

6 (2) by inserting before the period the following:

7 “\$750,000 for fiscal year 2010, and such sums as  
8 may be necessary for each of the fiscal years 2011  
9 through 2015.”.

10 **SEC. 208. COOPERATIVE AGREEMENTS FOR ONLINE DE-**  
11 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**  
12 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

13 Part B of title VII of the Public Health Service Act  
14 (42 U.S.C. 293 et seq.), as amended by section 204, is  
15 further amended by adding at the end the following:

16 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**  
17 **GREE PROGRAMS.**

18 “(a) COOPERATIVE AGREEMENTS.—The Secretary,  
19 acting through the Administrator of the Health Resources  
20 and Services Administration, in consultation with the Di-  
21 rector of the Centers for Disease Control and Prevention,  
22 the Director of the Agency for Healthcare Research and  
23 Quality, and the Director of the Office of Minority Health,  
24 shall award cooperative agreements to schools of public  
25 health and schools of allied health to design and imple-  
26 ment online degree programs.

1       “(b) PRIORITY.—In awarding cooperative agreements  
2 under this section, the Secretary shall give priority to any  
3 school of public health or school of allied health that has  
4 an established track record of serving medically under-  
5 served communities.

6       “(c) REQUIREMENTS.—Awardees must design and  
7 implement an online degree program, that meet the fol-  
8 lowing restrictions:

9               “(1) Enrollment of individuals who have ob-  
10       tained a secondary school diploma or its recognized  
11       equivalent.

12              “(2) Maintaining a significant enrollment of  
13       underrepresented minority or disadvantaged stu-  
14       dents.

15       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
16 are authorized to be appropriated to carry out this section,  
17 such sums as may be necessary for each of fiscal years  
18 2010 through 2015.”.

19 **SEC. 209. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**  
20 **SHIP PROGRAM.**

21       Part B of title VII of the Public Health Service Act  
22 (as amended by section 208) is further amended by adding  
23 at the end the following:

1 **“SEC. 744. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**  
2 **SHIP PROGRAM.**

3 “(a) IN GENERAL.—The Secretary may make grants  
4 to eligible schools for awarding scholarships to eligible in-  
5 dividuals to attend the school involved, for the purpose of  
6 enabling the individuals to make a career change from a  
7 non-health profession to a health profession.

8 “(b) EXPENSES.—Amounts awarded as a scholarship  
9 under this section—

10 “(1) subject to paragraph (2), may be expended  
11 only for tuition expenses, other reasonable edu-  
12 cational expenses, and reasonable living expenses in-  
13 curred in the attendance of the school involved; and

14 “(2) may be expended for stipends to eligible  
15 individuals for the enrolled period at eligible schools,  
16 except that such a stipend may not be provided to  
17 an individual for more than 4 years, and such a sti-  
18 pend may not exceed \$35,000 per year (notwith-  
19 standing any other provision of law regarding the  
20 amount of stipends).

21 “(c) DEFINITIONS.—In this section:

22 “(1) ELIGIBLE SCHOOL.—The term ‘eligible  
23 school’ means a school of medicine, osteopathic med-  
24 icine, dentistry, nursing (as defined in section 801),  
25 pharmacy, podiatric medicine, optometry, veterinary  
26 medicine, public health, chiropractic, or allied health,

1 a school offering a graduate program in mental and  
2 behavioral health practice, or an entity providing  
3 programs for the training of physician assistants  
4 and nurse midwives.

5 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
6 individual’ means an individual who has obtained a  
7 secondary school diploma or its recognized equiva-  
8 lent.

9 “(d) PRIORITY.—In providing scholarships to eligible  
10 individuals, eligible schools shall give to individuals from  
11 disadvantaged backgrounds.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated to carry out this section,  
14 such sums as may be necessary for each of fiscal years  
15 2010 through 2015.”.

16 **SEC. 210. NATIONAL REPORT ON THE PREPAREDNESS OF**  
17 **HEALTH PROFESSIONALS TO CARE FOR DI-**  
18 **VERSE POPULATIONS.**

19 The Secretary of Health and Human Services, in col-  
20 laboration with the Bureau of Health Professions, the Of-  
21 fice of Minority Health and the National Center on Minor-  
22 ity Health and Health Disparities, shall prepare and dis-  
23 seminate a report that details and assesses the prepared-  
24 ness of health professionals to care for racially and eth-  
25 nically diverse populations. Such information, which shall

1 be collected by the Bureau of Health Professions, shall  
2 include—

3 (1) with respect to health professions education,  
4 the number and percentage of hours of classroom  
5 discussion relating to minority health issues, includ-  
6 ing cultural competence;

7 (2) a description of the coursework involved in  
8 such education;

9 (3) a description of the results of an evaluation  
10 of the preparedness of students in such education;

11 (4) a description of the types of exposure that  
12 students have during their education to minority pa-  
13 tient populations; and

14 (5) a description of model programs and prac-  
15 tices.

16 **SEC. 211. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

17 Subtitle A of title XXXI of the Public Health Service  
18 Act, as amended by section 201, is further amended by  
19 adding at the end the following:

20 **“SEC. 3120B. DAVID SATCHER PUBLIC HEALTH AND**  
21 **HEALTH SERVICES CORPS.**

22 “(a) IN GENERAL.—The Administrator of the Health  
23 Resources and Services Administration and Director of  
24 the Centers for Disease Control and Prevention, in col-  
25 laboration with the Director of the Office of Minority

1 Health, shall award grants to eligible entities to increase  
2 awareness among post-primary and post-secondary stu-  
3 dents of career opportunities in the health professions.

4 “(b) ELIGIBILITY.—To be eligible to receive a grant  
5 under subsection (a) an entity shall—

6 “(1) be a clinical, public health or health serv-  
7 ices organization, community-based or non-profit en-  
8 tity, or other entity determined appropriate by the  
9 Director of the Centers for Disease Control and Pre-  
10 vention;

11 “(2) serve a health professional shortage area,  
12 as determined by the Secretary;

13 “(3) work with students, including those from  
14 racial and ethnic minority backgrounds, that have  
15 expressed an interest in the health professions; and

16 “(4) submit to the Secretary an application at  
17 such time, in such manner, and containing such in-  
18 formation as the Secretary may require.

19 “(c) USE OF FUNDS.—Grant awards under sub-  
20 section (a) shall be used to support internships that will  
21 increase awareness among students of non-research based  
22 and career opportunities in the following health profes-  
23 sions:

24 “(1) Medicine.

25 “(2) Nursing.



1 “(3) Public Health.

2 “(4) Pharmacy.

3 “(5) Health Administration and Management.

4 “(6) Health Policy.

5 “(7) Psychology.

6 “(8) Dentistry.

7 “(9) International Health.

8 “(10) Social Work.

9 “(11) Allied Health.

10 “(12) Psychiatry.

11 “(13) Hospice care.

12 “(14) Other professions deemed appropriate by  
13 the Director of the Centers for Disease Control and  
14 Prevention.

15 “(d) PRIORITY.—In awarding grants under sub-  
16 section (a), the Director of the Centers for Disease Con-  
17 trol and Prevention shall give priority to those entities  
18 that—

19 “(1) serve a high proportion of individuals from  
20 disadvantaged backgrounds;

21 “(2) have experience in health disparity elimi-  
22 nation programs;

23 “(3) facilitate the entry of disadvantaged indi-  
24 viduals into institutions of higher education; and

13       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
14 is authorized to be appropriated to carry out this section,  
15 such sums as may be necessary for each of fiscal years  
16 2010 through 2015.

19       “(a) IN GENERAL.—The Director of the Centers for  
20   Disease Control and Prevention, in collaboration with the  
21   Director of the Office of Minority Health, shall award  
22   scholarships to postsecondary students who seek a career  
23   in public health.

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1           “(1) have experience in public health research  
2           or public health practice, or other health professions  
3           as determined appropriate by the Director of the  
4           Centers for Disease Control and Prevention;

5           “(2) reside in a health professional shortage  
6           area as determined by the Secretary;

7           “(3) have expressed an interest in public health;

8           “(4) demonstrate promise for becoming a leader  
9           in public health;

10          “(5) secure admission to a 4-year institution of  
11          higher education;

12          “(6) comply with subsection (f); and

13          “(7) submit to the Secretary an application at  
14          such time, in such manner, and containing such in-  
15          formation as the Secretary may require.

16          “(c) USE OF FUNDS.—Amounts received under an  
17          award under subsection (a) shall be used to support oppor-  
18          tunities for students to become public health professionals.

19          “(d) PRIORITY.—In awarding grants under sub-  
20          section (a), the Director shall give priority to those stu-  
21          dents that—

22                 “(1) are from disadvantaged backgrounds;

23                 “(2) have secured admissions to a minority  
24          serving institution; and

13       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
14 is authorized to be appropriated to carry out this section,  
15 such sums as may be necessary for each of fiscal years  
16 2010 through 2015.

“(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, shall award research fellowships to post-baccalaureate students to conduct research that will examine

1 gender and health disparities and to pursue a career in  
2 the health professions.

3 “(b) ELIGIBILITY.—To be eligible to receive a fellow-  
4 ship under subsection (a) an individual shall—

5 “(1) have experience in health research or pub-  
6 lic health practice;

7 “(2) reside in a health professional shortage  
8 area as determined by the Secretary;

9 “(3) have expressed an interest in the health  
10 professions;

11 “(4) demonstrate promise for becoming a leader  
12 in the field of women’s health;

13 “(5) secure admission to a health professions  
14 school or graduate program with an emphasis in  
15 gender studies;

16 “(6) comply with subsection (f); and

17 “(7) submit to the Secretary an application at  
18 such time, in such manner, and containing such in-  
19 formation as the Secretary may require.

20 “(c) USE OF FUNDS.—Amounts received under an  
21 award under subsection (a) shall be used to support oppor-  
22 tunities for students to become researchers and advance  
23 the research base on the intersection between gender and  
24 health.

1       “(d) PRIORITY.—In awarding grants under sub-  
2 section (a), the Director of the Centers for Disease Con-  
3 trol and Prevention shall give priority to those applicants  
4 that—

5               “(1) are from disadvantaged backgrounds; and

6               “(2) have identified a mentor and academic ad-  
7 visor who will assist in the completion of their grad-  
8 uate or professional degree and have secured a re-  
9 search assistant position with a researcher working  
10 in the area of gender and health.

11       “(e) FELLOWSHIPS.—The Director of the Centers for  
12 Disease Control and Prevention may approve fellowships  
13 for individuals under this section for any period of edu-  
14 cation in the student’s graduate or health profession ten-  
15 ure, except that such a fellowship may not be provided  
16 to an individual for more than 3 years, and such a fellow-  
17 ship may not exceed \$18,000 per academic year (notwith-  
18 standing any other provision of law regarding the amount  
19 of fellowship).

20       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
21 is authorized to be appropriated to carry out this section,  
22 such sums as may be necessary for each of fiscal years  
23 2010 through 2015.

1 **“SEC. 3120E. PAUL DAVID WELLSTONE INTERNATIONAL**  
2 **HEALTH FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Agency for  
4 Healthcare Research and Quality, in collaboration with  
5 the Director of the Office of Minority Health, shall award  
6 research fellowships to college students or recent grad-  
7 uates to advance their understanding of international  
8 health.

9 “(b) ELIGIBILITY.—To be eligible to receive a fellow-  
10 ship under subsection (a) an individual shall—

11 “(1) have educational experience in the field of  
12 international health;

13 “(2) reside in a health professional shortage  
14 area as determined by the Secretary;

15 “(3) demonstrate promise for becoming a leader  
16 in the field of international health;

17 “(4) be a college senior or recent graduate of  
18 a four year higher education institution;

19 “(5) comply with subsection (f); and

20 “(6) submit to the Secretary an application at  
21 such time, in such manner, and containing such in-  
22 formation as the Secretary may require.

23 “(c) USE OF FUNDS.—Amounts received under an  
24 award under subsection (a) shall be used to support oppor-  
25 tunities for students to become health professionals and

1 to advance their knowledge about international issues re-  
2 lating to healthcare access and quality.

3 “(d) PRIORITY.—In awarding grants under sub-  
4 section (a), the Director shall give priority to those appli-  
5 cants that—

6 “(1) are from a disadvantaged background; and

7 “(2) have identified a mentor at a health pro-  
8 fessions school or institution, an academic advisor to  
9 assist in the completion of their graduate or profes-  
10 sional degree, and an advisor from an international  
11 health Non-Governmental Organization, Private Vol-  
12 unteer Organization, or other international institu-  
13 tion or program that focuses on increasing  
14 healthcare access and quality for residents in devel-  
15 oping countries.

16 “(e) FELLOWSHIPS.—The Secretary shall approve  
17 fellowships for college seniors or recent graduates, except  
18 that such a fellowship may not be provided to an indi-  
19 vidual for more than 6 months, may not be awarded to  
20 a graduate that has not been enrolled in school for more  
21 than 1 year, and may not exceed \$4,000 per academic year  
22 (notwithstanding any other provision of law regarding the  
23 amount of fellowship).

24 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
25 is authorized to be appropriated to carry out this section,



1 such sums as may be necessary for each of fiscal years  
2 2010 through 2015.

3 **“SEC. 3120F. EDWARD R. ROYBAL HEALTHCARE SCHOLAR**  
4 **PROGRAM.**

5 “(a) IN GENERAL.—The Director of the Agency for  
6 Healthcare Research and Quality, the Director of the Cen-  
7 ters for Medicaid and Medicare, and the Administrator for  
8 Health Resources and Services Administration, in collabo-  
9 ration with the Director of the Office of Minority Health,  
10 shall award grants to eligible entities to expose entering  
11 graduate students to the health professions.

12 “(b) ELIGIBILITY.—To be eligible to receive a grant  
13 under subsection (a) an entity shall—

14 “(1) be a clinical, public health or health serv-  
15 ices organization, community-based or non-profit en-  
16 tity, or other entity determined appropriate by the  
17 Director of the Agency for Healthcare Research and  
18 Quality;

19 “(2) serve in a health professional shortage  
20 area as determined by the Secretary;

21 “(3) work with students obtaining a degree in  
22 the health professions; and

23 “(4) submit to the Secretary an application at  
24 such time, in such manner, and containing such in-  
25 formation as the Secretary may require.

1       “(c) USE OF FUNDS.—Amounts received under a  
2 grant awarded under subsection (a) shall be used to sup-  
3 port opportunities that expose students to non-research  
4 based health professions, including—

5               “(1) public health policy;

6               “(2) healthcare and pharmaceutical policy;

7               “(3) healthcare administration and manage-  
8 ment;

9               “(4) health economics; and

10              “(5) other professions determined appropriate  
11 by the Director of the Agency for Healthcare Re-  
12 search and Quality.

13       “(d) PRIORITY.—In awarding grants under sub-  
14 section (a), the Director of the Agency for Healthcare Re-  
15 search and Quality shall give priority to those entities  
16 that—

17              “(1) have experience with health disparity elimi-  
18 nation programs;

19              “(2) facilitate training in the fields described in  
20 subsection (c); and

21              “(3) provide counseling or other services de-  
22 signed to assist such individuals in successfully com-  
23 pleting their education at the post-secondary level.

24       “(e) STIPENDS.—The Secretary may approve the  
25 payment of stipends for individuals under this section for

1 any period of education in student-enhancement programs  
2 (other than regular courses) at health professions schools  
3 or entities, except that such a stipend may not be provided  
4 to an individual for more than 2 months, and such a sti-  
5 pend may not exceed \$100 per day (notwithstanding any  
6 other provision of law regarding the amount of stipends).

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
8 is authorized to be appropriated to carry out this section  
9 such sums as may be necessary for each of fiscal years  
10 2010 through 2015.”.

11 **SEC. 212. ADVISORY COMMITTEE ON HEALTH PROFES-**  
12 **SIONS TRAINING FOR DIVERSITY.**

13 (a) ESTABLISHMENT.—The Secretary of Health and  
14 Human Services (referred to in this section as the “Sec-  
15 retary”) shall establish an advisory committee to be known  
16 as the Advisory Committee on Health Professions Train-  
17 ing for Diversity (in this section referred to as the “Advi-  
18 sory Committee”).

19 (b) COMPOSITION.—

20 (1) IN GENERAL.—The Secretary shall deter-  
21 mine the appropriate number of individuals to serve  
22 on the Advisory Committee. Such individuals shall  
23 not be officers or employees of the Federal Govern-  
24 ment.

1           (2) APPOINTMENT.—Not later than 60 days  
2 after the date of enactment of this section, the Sec-  
3 retary shall appoint the members of the Advisory  
4 Committee from among individuals who are health  
5 professionals. In making such appointments, the  
6 Secretary shall ensure a fair balance between the  
7 health professions, that at least 75 percent of the  
8 members of the Advisory Committee are health pro-  
9 fessionals, a broad geographic representation of  
10 members and a balance between urban and rural  
11 members. Members shall be appointed based on their  
12 competence, interest, and knowledge of the mission  
13 of the profession involved.

14           (3) MINORITY REPRESENTATION.—In appoint-  
15 ing the members of the Advisory Committee under  
16 paragraph (2), the Secretary shall ensure the ade-  
17 quate representation of women and minorities.

18           (c) TERMS.—

19           (1) IN GENERAL.—A member of the Advisory  
20 Committee shall be appointed for a term of 3 years,  
21 except that of the members first appointed—

22                   (A)  $\frac{1}{3}$  of such members shall serve for a  
23 term of 1 year;

24                   (B)  $\frac{1}{3}$  of such members shall serve for a  
25 term of 2 years; and

1 (C)  $\frac{1}{3}$  of such members shall serve for a  
2 term of 3 years.

3 (2) VACANCIES.—

4 (A) IN GENERAL.—A vacancy on the Advi-  
5 sory Committee shall be filled in the manner in  
6 which the original appointment was made and  
7 shall be subject to any conditions which applied  
8 with respect to the original appointment.

9 (B) FILLING UNEXPIRED TERM.—An indi-  
10 vidual chosen to fill a vacancy shall be ap-  
11 pointed for the unexpired term of the member  
12 replaced.

13 (d) DUTIES.—

14 (1) IN GENERAL.—The Advisory Committee  
15 shall—

16 (A) provide advice and recommendations to  
17 the Secretary concerning policy and program  
18 development and other matters of significance  
19 concerning activities under this part; and

20 (B) not later than 2 years after the date  
21 of enactment of this section, and annually  
22 thereafter, prepare and submit to the Secretary,  
23 and the Committee on Health, Education,  
24 Labor and Pensions of the Senate, and the  
25 Committee on Energy and Commerce of the

1 House of Representatives, a report describing  
2 the activities of the Committee.

3 (2) CONSULTATION WITH STUDENTS.—In car-  
4 rying out duties under paragraph (1), the Advisory  
5 Committee shall consult with individuals who are at-  
6 tending health professions schools with which this  
7 part is concerned.

8 (e) MEETINGS AND DOCUMENTS.—

9 (1) MEETINGS.—The Advisory Committee shall  
10 meet not less than 2 times each year. Such meetings  
11 shall be held jointly with other related entities estab-  
12 lished under this title where appropriate.

13 (2) DOCUMENTS.—Not later than 14 days prior  
14 to the convening of a meeting under paragraph (1),  
15 the Advisory Committee shall prepare and make  
16 available an agenda of the matters to be considered  
17 by the Advisory Committee at such meeting. At any  
18 such meeting, the Advisory Committee shall dis-  
19 tribute materials with respect to the issues to be ad-  
20 dressed at the meeting. Not later than 30 days after  
21 the adjourning of such a meeting, the Advisory Com-  
22 mittee shall prepare and make available a summary  
23 of the meeting and any actions taken by the Com-  
24 mittee based upon the meeting.

25 (f) COMPENSATION AND EXPENSES.—

1           (1) COMPENSATION.—Each member of the Ad-  
2       visory Committee shall be compensated at a rate  
3       equal to the daily equivalent of the annual rate of  
4       basic pay prescribed for level IV of the Executive  
5       Schedule under section 5315 of title 5, United  
6       States Code, for each day (including travel time)  
7       during which such member is engaged in the per-  
8       formance of the duties of the Committee.

9           (2) EXPENSES.—The members of the Advisory  
10      Committee shall be allowed travel expenses, includ-  
11      ing per diem in lieu of subsistence, at rates author-  
12      ized for employees of agencies under subchapter I of  
13      chapter 57 of title 5, United States Code, while  
14      away from their homes or regular places of business  
15      in the performance of services for the Committee.

16      (g) FACA.—The Federal Advisory Committee Act  
17      shall apply to the Advisory Committee under this section  
18      only to the extent that the provisions of such Act do not  
19      conflict with the requirements of this section.

20      **SEC. 213. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**  
21                                      **PROGRAM.**

22      Section 402E of the Higher Education Act of 1965  
23      (20 U.S.C. 1070a–15) is amended by striking subsection  
24      (g) and inserting the following:

1       “(g) COLLABORATION IN HEALTH PROFESSION DI-  
 2       VERSITY TRAINING PROGRAMS.—The Secretary of Edu-  
 3       cation shall coordinate with the Secretary of Health and  
 4       Human Services to ensure that there is collaboration be-  
 5       tween the goals of the program under this section and pro-  
 6       grams of the Health Resources and Services Administra-  
 7       tion that promote health workforce diversity. The Sec-  
 8       retary of Education shall take such measures as may be  
 9       necessary to encourage participants in programs under  
 10      this section to consider health profession careers.

11      “(h) FUNDING.—From amounts appropriated pursu-  
 12      ant to the authority of section 402A(g), the Secretary  
 13      shall, to the extent practicable, allocate funds for projects  
 14      authorized by this section in an amount which is not less  
 15      than \$31,000,000 for each of the fiscal years 2010  
 16      through 2016.”.

## 17      **TITLE III—DATA COLLECTION** 18                                   **AND REPORTING**

### 19      **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 20                                   **ACT.**

21      (a) PURPOSE.—It is the purpose of this section to  
 22      promote data collection, analysis, and reporting by race,  
 23      ethnicity, and primary language among federally sup-  
 24      ported health programs.



1 (b) AMENDMENT.—Title XXXI of the Public Health  
2 Service Act, as amended by title II of this Act, is further  
3 amended by adding at the end the following:

4 **“Subtitle B—Strengthening Data**  
5 **Collection, Improving Data**  
6 **Analysis, and Expanding Data**  
7 **Reporting**

8 **“SEC. 3131. DATA ON RACE, ETHNICITY, AND PRIMARY LAN-**  
9 **GUAGE.**

10 **“(a) REQUIREMENTS.—**

11 **“(1) IN GENERAL.—**Each health-related pro-  
12 gram operated by or that receives funding or reim-  
13 bursement, in whole or in part, either directly or in-  
14 directly from the Department of Health and Human  
15 Services shall—

16 **“(A) require the collection, by the agency**  
17 **or program involved, of data on the race, eth-**  
18 **nicity, primary language, and sexual orientation**  
19 **of each applicant for and recipient of health-re-**  
20 **lated assistance under such program—**

21 **“(i) using, at a minimum, the cat-**  
22 **egories for race and ethnicity described in**  
23 **the 1997 Office of Management and Budg-**  
24 **et Standards for Maintaining, Collecting,**

1 and Presenting Federal Data on Race and  
2 Ethnicity;

3 “(ii) using the standards developed  
4 under subsection (e) for the collection of  
5 language data;

6 “(iii) collecting data for additional  
7 population groups if such groups can be  
8 aggregated into the minimum race and  
9 ethnicity categories; and

10 “(iv) where practicable, through self-  
11 report;

12 “(B) with respect to the collection of the  
13 data described in subparagraph (A) for appli-  
14 cants and recipients who are minors or other-  
15 wise legally incapacitated, require that—

16 “(i) such data be collected from the  
17 parent or legal guardian of such an appli-  
18 cant or recipient; and

19 “(ii) the preferred language of the  
20 parent or legal guardian of such an appli-  
21 cant or recipient be collected;

22 “(C) systematically analyze such data  
23 using the smallest appropriate units of analysis  
24 feasible to detect racial and ethnic disparities as  
25 well as disparities along lines of sexual orienta-

tion in health and health care and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

“(D) provide such data to the Secretary on at least an annual basis; and

“(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, primary language, gender, and sexual orientation data.

“(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

“(A) permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

1                   “(B) require health care providers to col-  
2                   lect data.

3           “(b) PROTECTION OF DATA.—The Secretary shall  
4 ensure (through the promulgation of regulations or other-  
5 wise) that all data collected pursuant to subsection (a) is  
6 protected—

7                   “(1) under the same privacy protections as the  
8           Secretary applies to other health data under the reg-  
9           ulations promulgated under section 264(c) of the  
10          Health Insurance Portability and Accountability Act  
11          of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
12          lating to the privacy of individually identifiable  
13          health information and other protections; and

14                   “(2) from all inappropriate internal use by any  
15          entity that collects, stores, or receives the data, in-  
16          cluding use of such data in determinations of eligi-  
17          bility (or continued eligibility) in health plans, and  
18          from other inappropriate uses, as defined by the  
19          Secretary.

20          “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The  
21 Secretary shall develop and implement a national plan to  
22 ensure the collection of data in a culturally appropriate  
23 and competent manner, and to improve the collection,  
24 analysis, and reporting of racial, ethnic, and primary lan-  
25 guage data at the Federal, State, territorial, Tribal, and

1 local levels, including data to be collected under subsection  
2 (a). The Data Council of the Department of Health and  
3 Human Services, in consultation with the National Com-  
4 mittee on Vital Health Statistics, the Office of Minority  
5 Health, and other appropriate public and private entities,  
6 shall make recommendations to the Secretary concerning  
7 the development, implementation, and revision of the na-  
8 tional plan. Such plan shall include recommendations on  
9 how to—

10           “(1) implement subsection (a) while minimizing  
11           the cost and administrative burdens of data collec-  
12           tion and reporting;

13           “(2) expand awareness among Federal agencies,  
14           States, territories, Indian tribes, health providers,  
15           health plans, health insurance issuers, and the gen-  
16           eral public that data collection, analysis, and report-  
17           ing by race, ethnicity, and primary language is legal  
18           and necessary to assure equity and non-discrimina-  
19           tion in the quality of health care services;

20           “(3) ensure that future patient record systems  
21           have data code sets for racial, ethnic, primary lan-  
22           guage, and sexual orientation identifiers and that  
23           such identifiers can be retrieved from clinical  
24           records, including records transmitted electronically;

1           “(4) improve health and health care data collec-  
2           tion and analysis for more population groups if such  
3           groups can be aggregated into the minimum race  
4           and ethnicity categories, including exploring the fea-  
5           sibility of enhancing collection efforts in States for  
6           racial and ethnic groups that comprise a significant  
7           proportion of the population of the State;

8           “(5) provide researchers with greater access to  
9           racial, ethnic, and primary language data, subject to  
10          privacy and confidentiality regulations; and

11          “(6) safeguard and prevent the misuse of data  
12          collected under subsection (a).

13          “(d) COMPLIANCE WITH STANDARDS.—Data col-  
14          lected under subsection (a) shall be obtained, maintained,  
15          and presented (including for reporting purposes) in ac-  
16          cordance with the 1997 Office of Management and Budget  
17          Standards for Maintaining, Collecting, and Presenting  
18          Federal Data on Race and Ethnicity (at a minimum).

19          “(e) LANGUAGE COLLECTION STANDARDS.—Not  
20          later than 1 year after the date of enactment of this title,  
21          the Deputy Assistant Secretary for Minority Health, in  
22          consultation with the Office for Civil Rights of the Depart-  
23          ment of Health and Human Services, shall develop and  
24          disseminate Standards for the Classification of Federal  
25          Data on Preferred Written and Spoken Language.

1       “(f) TECHNICAL ASSISTANCE FOR THE COLLECTION  
2 AND REPORTING OF DATA.—

3           “(1) IN GENERAL.—The Secretary may, either  
4 directly or through grant or contract, provide tech-  
5 nical assistance to enable a health care program or  
6 an entity operating under such program to comply  
7 with the requirements of this section.

8           “(2) TYPES OF ASSISTANCE.—Assistance pro-  
9 vided under this subsection may include assistance  
10 to—

11           “(A) enhance or upgrade computer tech-  
12 nology that will facilitate racial, ethnic, and pri-  
13 mary language data collection and analysis;

14           “(B) improve methods for health data col-  
15 lection and analysis including additional popu-  
16 lation groups beyond the Office of Management  
17 and Budget categories if such groups can be  
18 aggregated into the minimum race and ethnicity  
19 categories;

20           “(C) develop mechanisms for submitting  
21 collected data subject to existing privacy and  
22 confidentiality regulations; and

23           “(D) develop educational programs to in-  
24 form health insurance issuers, health plans,  
25 health providers, health-related agencies, and

1           the general public that data collection and re-  
2           porting by race, ethnicity, and preferred lan-  
3           guage are legal and essential for eliminating  
4           health and health care disparities.

5           “(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The  
6   Secretary, acting through the Director of the Agency for  
7   Healthcare Research and Quality and in coordination with  
8   the Administrator of the Centers for Medicare & Medicaid  
9   Services, shall provide technical assistance to agencies of  
10  the Department of Health and Human Services in meeting  
11  Federal standards for race, ethnicity, and primary lan-  
12  guage data collection and analysis of racial and ethnic dis-  
13  parities in health and health care in public programs by—

14           “(1) identifying appropriate quality assurance  
15       mechanisms to monitor for health disparities;

16           “(2) specifying the clinical, diagnostic, or thera-  
17       peutic measures which should be monitored;

18           “(3) developing new quality measures relating  
19       to racial and ethnic disparities in health and health  
20       care;

21           “(4) identifying the level at which data analysis  
22       should be conducted; and

23           “(5) sharing data with external organizations  
24       for research and quality improvement purposes.



1       “(h) REPORT.—Not later than 2 years after the date  
2 of enactment of this title, and biennially thereafter, the  
3 Secretary shall submit to the appropriate committees of  
4 Congress a report on the effectiveness of data collection,  
5 analysis, and reporting on race, ethnicity, and primary  
6 language under the programs and activities of the Depart-  
7 ment of Health and Human Services and under other Fed-  
8 eral data collection systems with which the Department  
9 interacts to collect relevant data on race and ethnicity.  
10 The report shall evaluate the progress made in the De-  
11 partment with respect to the national plan under sub-  
12 section (c) or subsequent revisions thereto.

13       “(i) DEFINITION.—In this section, the term ‘health-  
14 related program’ mean a program—

15               “(1) under the Social Security Act (42 U.S.C.  
16       301 et seq.) that pay for health care and services;  
17       and

18               “(2) under this Act that provide Federal finan-  
19       cial assistance for health care, biomedical research,  
20       health services research, and programs designed to  
21       improve the public’s health.

22       “(j) AUTHORIZATION OF APPROPRIATIONS.—There  
23 are authorized to be appropriated to carry out this section,  
24 such sums as may be necessary for each of fiscal years  
25 2010 through 2015.

1 **“SEC. 3132. PROVISIONS RELATING TO NATIVE AMERICANS.**

2       “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-  
3 TERS.—The Secretary shall establish an epidemiology cen-  
4 ter in each service area to carry out the functions de-  
5 scribed in subsection (b). Any new center established after  
6 the date of the enactment of the Health Equity and Ac-  
7 countability Act of 2009 may be operated under a grant  
8 authorized by subsection (d), but funding under such a  
9 grant shall not be divisible.

10       “(b) FUNCTIONS OF CENTERS.—In consultation with  
11 and upon the request of Indian Tribes, Tribal Organiza-  
12 tions, and Urban Indian Organizations, each service area  
13 epidemiology center established under this subsection  
14 shall, with respect to such service area—

15               “(1) collect data relating to, and monitor  
16 progress made toward meeting, each of the health  
17 status objectives of the Service, the Indian Tribes,  
18 Tribal Organizations, and Urban Indian Organiza-  
19 tions in the service area;

20               “(2) evaluate existing delivery systems, data  
21 systems, and other systems that impact the improve-  
22 ment of Indian health;

23               “(3) assist Indian Tribes, Tribal Organizations,  
24 and Urban Indian Organizations in identifying their  
25 highest priority health status objectives and the

1 services needed to achieve such objectives, based on  
2 epidemiological data;

3 “(4) make recommendations for the targeting  
4 of services needed by the populations served;

5 “(5) make recommendations to improve health  
6 care delivery systems for Indians and Urban Indi-  
7 ans;

8 “(6) provide requested technical assistance to  
9 Indian Tribes, Tribal Organizations, and Urban In-  
10 dian Organizations in the development of local  
11 health service priorities and incidence and prevalence  
12 rates of disease and other illness in the community;  
13 and

14 “(7) provide disease surveillance and assist In-  
15 dian Tribes, Tribal Organizations, and Urban Indian  
16 Organizations to promote public health.

17 “(c) TECHNICAL ASSISTANCE.—The Director of the  
18 Centers for Disease Control and Prevention shall provide  
19 technical assistance to the centers in carrying out the re-  
20 quirements of this subsection.

21 “(d) GRANTS FOR STUDIES.—

22 “(1) IN GENERAL.—The Secretary may make  
23 grants to Indian Tribes, Tribal Organizations,  
24 Urban Indian Organizations, and eligible intertribal

1 consortia to conduct epidemiological studies of In-  
2 dian communities.

3 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An  
4 intertribal consortium is eligible to receive a grant  
5 under this subsection if—

6 “(A) the intertribal consortium is incor-  
7 porated for the primary purpose of improving  
8 Indian health; and

9 “(B) the intertribal consortium is rep-  
10 resentative of the Indian Tribes or urban In-  
11 dian communities in which the intertribal con-  
12 sortium is located.

13 “(3) APPLICATIONS.—An application for a  
14 grant under this subsection shall be submitted in  
15 such manner and at such time as the Secretary shall  
16 prescribe.

17 “(4) REQUIREMENTS.—An applicant for a  
18 grant under this subsection shall—

19 “(A) demonstrate the technical, adminis-  
20 trative, and financial expertise necessary to  
21 carry out the functions described in paragraph  
22 (5);

23 “(B) consult and cooperate with providers  
24 of related health and social services in order to  
25 avoid duplication of existing services; and

1           “(C) demonstrate cooperation from Indian  
2           tribes or Urban Indian Organizations in the  
3           area to be served.

4           “(5) USE OF FUNDS.—A grant awarded under  
5           paragraph (1) may be used—

6           “(A) to carry out the functions described  
7           in subsection (b);

8           “(B) to provide information to and consult  
9           with tribal leaders, urban Indian community  
10          leaders, and related health staff on health care  
11          and health service management issues; and

12          “(C) in collaboration with Indian Tribes,  
13          Tribal Organizations, and urban Indian com-  
14          munities, to provide the Service with informa-  
15          tion regarding ways to improve the health sta-  
16          tus of Indians.

17          “(e) ACCESS TO INFORMATION.—An epidemiology  
18          center operated by a grantee pursuant to a grant awarded  
19          under subsection (d) shall be treated as a public health  
20          authority for purposes of the Health Insurance Portability  
21          and Accountability Act of 1996 (Public Law 104–191; 110  
22          Stat. 2033), as such entities are defined in part 164.501  
23          of title 45, Code of Federal Regulations (or a successor  
24          regulation). The Secretary shall grant such grantees ac-  
25          cess to and use of data, data sets, monitoring systems,

1 delivery systems, and other protected health information  
2 in the possession of the Secretary.”.

3 **SEC. 302. COLLECTION OF RACE AND ETHNICITY DATA BY**  
4 **THE SOCIAL SECURITY ADMINISTRATION.**

5 Part A of title XI of the Social Security Act (42  
6 U.S.C. 1301 et seq.) is amended by adding at the end  
7 the following:

8 **“SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA**  
9 **BY THE SOCIAL SECURITY ADMINISTRATION.**

10 “(a) REQUIREMENT.—The Commissioner of Social  
11 Security, in consultation with the Administrator of the  
12 Centers for Medicare & Medicaid Services, shall—

13 “(1) require the collection of data on the race,  
14 ethnicity, and primary language of all applicants for  
15 social security account numbers or benefits under  
16 title II or part A of title XVIII and all individuals  
17 with respect to whom the Commissioner maintains  
18 records of wages and self-employment income in ac-  
19 cordance with reports received by the Commissioner  
20 or the Secretary of the Treasury—

21 “(A) using, at a minimum, the categories  
22 for race and ethnicity described in the 1997 Of-  
23 fice of Management and Budget Standards for  
24 Maintaining, Collecting, and Presenting Federal

1 Data on Race and Ethnicity and available lan-  
2 guage standards; and

3 “(B) where practicable, collecting data for  
4 additional population groups if such groups can  
5 be aggregated into the minimum race and eth-  
6 nicity categories;

7 “(2) with respect to the collection of the data  
8 described in paragraph (1) for applicants who are  
9 under 18 years of age or otherwise legally incapac-  
10 itated, require that—

11 “(A) such data be collected from the par-  
12 ent or legal guardian of such an applicant; and

13 “(B) the primary language of the parent  
14 or legal guardian of such an applicant or recipi-  
15 ent be used;

16 “(3) require that such data be uniformly ana-  
17 lyzed and reported at least annually to the Commis-  
18 sioner of Social Security;

19 “(4) be responsible for storing the data re-  
20 ported under paragraph (3);

21 “(5) ensure transmission to the Centers for  
22 Medicare & Medicaid Services and other Federal  
23 health agencies;

24 “(6) provide such data to the Secretary on at  
25 least an annual basis; and

1           “(7) ensure that the provision of assistance to  
2           an applicant is not denied or otherwise adversely af-  
3           fected because of the failure of the applicant to pro-  
4           vide race, ethnicity, and primary language data.

5           “(b) PROTECTION OF DATA.—The Commissioner of  
6 Social Security shall ensure (through the promulgation of  
7 regulations or otherwise) that all data collected pursuant  
8 subsection (a) is protected—

9           “(1) under the same privacy protections as the  
10          Secretary applies to health data under the regula-  
11          tions promulgated under section 264(c) of the  
12          Health Insurance Portability and Accountability Act  
13          of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
14          lating to the privacy of individually identifiable  
15          health information and other protections; and

16          “(2) from all inappropriate internal use by any  
17          entity that collects, stores, or receives the data, in-  
18          cluding use of such data in determinations of eligi-  
19          bility (or continued eligibility) in health plans, and  
20          from other inappropriate uses, as defined by the  
21          Secretary.

22          “(c) RULE OF CONSTRUCTION.—Nothing in this sec-  
23          tion shall be construed to permit the use of information  
24          collected under this section in a manner that would ad-



1 versely affect any individual providing any such informa-  
2 tion.

3 “(d) TECHNICAL ASSISTANCE.—The Secretary may,  
4 either directly or by grant or contract, provide technical  
5 assistance to enable any health entity to comply with the  
6 requirements of this section.

7 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated to carry out this section,  
9 such sums as may be necessary for each of fiscal years  
10 2010 through 2015.”.

11 **SEC. 303. REVISION OF HIPAA CLAIMS STANDARDS.**

12 (a) IN GENERAL.—Not later than 1 year after the  
13 date of enactment of this Act, the Secretary of Health and  
14 Human Services shall revise the regulations promulgated  
15 under part C of title XI of the Social Security Act (42  
16 U.S.C. 1320d et seq.), as added by the Health Insurance  
17 Portability and Accountability Act of 1996 (Public Law  
18 104–191), relating to the collection of data on race, eth-  
19 nicity, and primary language in a health-related trans-  
20 action to require—

21 (1) the use, at a minimum, of the categories for  
22 race and ethnicity described in the 1997 Office of  
23 Management and Budget Standards for Maintain-  
24 ing, Collecting, and Presenting Federal Data on  
25 Race and Ethnicity;

1           (2) the establishment of a new data code set for  
2       primary language; and

3           (3) the designation of the racial, ethnic, and  
4       primary language code sets as “required” for claims  
5       and enrollment data.

6       (b) DISSEMINATION.—The Secretary of Health and  
7   Human Services shall disseminate the new standards de-  
8   veloped under subsection (a) to all health entities that are  
9   subject to the regulations described in such subsection and  
10   provide technical assistance with respect to the collection  
11   of the data involved.

12       (c) COMPLIANCE.—The Secretary of Health and  
13   Human Services shall require that health entities comply  
14   with the new standards developed under subsection (a) not  
15   later than 2 years after the final promulgation of such  
16   standards.

17   **SEC. 304. NATIONAL CENTER FOR HEALTH STATISTICS.**

18       Section 306(n) of the Public Health Service Act (42  
19   U.S.C. 242k(n)) is amended—

20           (1) in paragraph (1), by striking “2003” and  
21       inserting “2014”;

22           (2) in paragraph (2), in the first sentence, by  
23       striking “2003” and inserting “2014”; and

24           (3) in paragraph (3), by striking “2002” and  
25       inserting “2014”.

1 **SEC. 305. GEO-ACCESS STUDY.**

2       The Administrator of the Substance Abuse and Men-  
3 tal Health Services Administration shall—

4           (1) conduct a study to—

5               (A) determine which geographic areas of  
6 the United States have shortages of specialty  
7 mental health providers; and

8               (B) assess the preparedness of speciality  
9 mental health providers to deliver culturally and  
10 linguistically appropriate services; and

11          (2) submit a report to the Congress on the re-  
12 sults of such study.

13 **SEC. 306. RACIAL, ETHNIC, AND LINGUISTIC DATA COL-**  
14 **LECTED BY THE FEDERAL GOVERNMENT.**

15       (a) COLLECTION; SUBMISSION.—Not later than 90  
16 days after the date of the enactment of this Act, and Jan-  
17 uary 31st of each year thereafter, each department, agen-  
18 cy, and office of the Federal Government that has col-  
19 lected racial, ethnic, or linguistic data during the pre-  
20 ceding calendar year shall submit such data to the Sec-  
21 retary of Health and Human Services.

22       (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—  
23 Not later than April 30, 2010, and each April 30th there-  
24 after, the Secretary of Health and Human Services, acting  
25 through the Director of the National Center on Minority

1 Health and Health Disparities and the Deputy Assistant  
2 Secretary for Minority Health, shall—

3           (1) collect and analyze the racial, ethnic, and  
4       linguistic data submitted under subsection (a) for  
5       the preceding calendar year;

6           (2) make publicly available such data and the  
7       results of such analysis; and

8           (3) submit a report to the Congress on such  
9       data and analysis.

10 **SEC. 307. HEALTH INFORMATION TECHNOLOGY GRANTS.**

11       (a) **AUTHORITY.**—The Deputy Assistant Secretary  
12 for Minority Health, in coordination with the Office of the  
13 National Coordinator for Health Information Technology,  
14 the Health Resources and Services Administration, the  
15 Substance Abuse and Mental Health Services Administra-  
16 tion, and the National Center on Minority Health and  
17 Health Disparities, may award grants to appropriate enti-  
18 ties for the purpose of ensuring appropriate and best prac-  
19 tices to collect appropriate data and documents on the re-  
20 duction of health disparities.

21       (b) **USE OF FUNDS.**—A grant received under sub-  
22 section (a) shall be used to achieve the purpose described  
23 in such subsection through one or more of the following:

24           (1) Purchasing new, or enhancing existing,  
25       health information technology.

1           (2) Providing support and training to providers  
2           concerning such technology.

3           (3) Conducting outreach and education on  
4           health information technology and its benefits to pa-  
5           tients, physicians, allied health professionals, and  
6           advocacy groups in medically underserved commu-  
7           nities (as defined in section 799B of the Public  
8           Health Service Act (42 U.S.C. 295p)).

9           (c) AUTHORIZATION OF APPROPRIATIONS.—To carry  
10          out this section, there are authorized to be appropriated  
11          \$20,000,000 for each of fiscal years 2010 through 2015.

12   **SEC. 308. STUDY OF HEALTH INFORMATION TECHNOLOGY**  
13                   **IN MEDICALLY UNDERSERVED COMMU-**  
14                   **NITIES.**

15          (a) STUDY.—The National Coordinator for Health  
16          Information Technology shall conduct a study on the de-  
17          velopment and implementation of health information tech-  
18          nology in medically underserved communities. The study  
19          shall—

20               (1) identify barriers to successful implementa-  
21               tion of health information technology in these com-  
22               munities;

23               (2) examine the impact of health information  
24               technology on providing quality care and reducing  
25               the cost of care to these communities;

1           (3) examine urban and rural community health  
2           systems and determine the impact that health infor-  
3           mation technology may have on the capacity of pri-  
4           mary health providers; and

5           (4) assess the feasibility and the costs of associ-  
6           ated with the use of health information technology  
7           in these communities.

8           (b) REPORT.—Not later than 18 months after the  
9           date of the enactment of this Act, the National Coordi-  
10          nator for Health Information Technology shall submit to  
11          the Congress a report on the study conducted under sub-  
12          section (a) and shall include in such report such rec-  
13          ommendations for legislation or administrative action as  
14          the Coordinator determines appropriate.

15   **SEC. 309. HEALTH INFORMATION TECHNOLOGY IN MEDI-**  
16                           **CALLY UNDERSERVED COMMUNITIES.**

17          The National Coordinator for Health Information  
18          Technology shall—

19               (1) identify sources of funds that will be made  
20               available to promote and support the planning and  
21               adoption of health information technology in medi-  
22               cally underserved communities (as defined in section  
23               799B of the Public Health Service Act (42 U.S.C.  
24               295p)), including in urban and rural areas, either  
25               through grants or technical assistance;

1           (2) coordinate with the funding sources to help  
2       such communities connect to identified funding; and  
3           (3) collaborate with the Agency for Healthcare  
4       Research and Quality, the Health Resources and  
5       Services Administration, and other Federal agencies  
6       to support technical assistance, knowledge dissemi-  
7       nation, and resource development, to such commu-  
8       nities seeking to plan for and adopt technology and  
9       establish electronic health information networks  
10      across providers.

11 **SEC. 310. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**  
12 **NORITY-SERVING INSTITUTIONS.**

13       (a) **AUTHORITY.**—The Secretary of Health and  
14 Human Services, acting through the Center on Minority  
15 Health and Health Disparities and the Office of Minority  
16 Health, may award grants to access and analyze racial and  
17 ethnic, and where possible, primary language data to mon-  
18 itor and report on progress to reduce and eliminate racial  
19 and ethnic disparities in health and health care.

20       (b) **ELIGIBLE ENTITY.**—In this section, the term “el-  
21 igible entity” means a historically Black college or univer-  
22 sity, an Hispanic-serving institution, a tribal college or  
23 university, or an Asian American and Pacific Islander-  
24 serving institution with an accredited public health, health  
25 policy, or health services research program.

1 **SEC. 311. HEALTH INFORMATION TECHNOLOGY GRANTS**  
2 **FOR RURAL HEALTH CARE PROVIDERS.**

3 Title II of the Public Health Service Act is amended  
4 by adding at the end the following new part:

5 **“PART D—HEALTH INFORMATION TECHNOLOGY**  
6 **GRANTS**

7 **“SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD**  
8 **ADOPTION OF INTEROPERABLE HEALTH IN-**  
9 **FORMATION TECHNOLOGY IN RURAL AREAS.**

10 **“(a) COMPETITIVE GRANTS TO ELIGIBLE ENTITIES**  
11 **IN RURAL AREAS.—**

12 **“(1) IN GENERAL.—**The Secretary may award  
13 competitive grants to eligible entities in rural areas  
14 to facilitate the purchase and enhance the utilization  
15 of qualified health information technology systems to  
16 improve the quality and efficiency of health care.

17 **“(2) ELIGIBILITY.—**To be eligible to receive a  
18 grant under paragraph (1) an entity shall—

19 **“(A)** submit to the Secretary an applica-  
20 tion at such time, in such manner, and con-  
21 taining such information as the Secretary may  
22 require;

23 **“(B)** submit to the Secretary a strategic  
24 plan for the implementation of data sharing  
25 and interoperability measures;

26 **“(C)** be a rural health care provider;



1           “(D) adopt any applicable core interoper-  
2           ability guidelines (endorsed under other provi-  
3           sions of law);

4           “(E) agree to notify patients if their indi-  
5           vidually identifiable health information is  
6           wrongfully disclosed;

7           “(F) demonstrate significant financial  
8           need; and

9           “(G) provide matching funds in accordance  
10          with paragraph (4).

11          “(3) USE OF FUNDS.—Amounts received under  
12          a grant under this subsection shall be used to facili-  
13          tate the purchase and enhance the utilization of  
14          qualified health information technology systems and  
15          training personnel in the use of such technology.

16          “(4) MATCHING REQUIREMENT.—To be eligible  
17          for a grant under this subsection an entity shall con-  
18          tribute non-Federal contributions to the costs of car-  
19          rying out the activities for which the grant is award-  
20          ed in an amount equal to \$1 for each \$3 of Federal  
21          funds provided under the grant.

22          “(5) LIMIT ON GRANT AMOUNT.—In no case  
23          shall the payment amount under this subsection with  
24          respect to the purchase or enhanced utilization of  
25          qualified health information technology for a rural

1 health care provider, in addition to the amount of  
2 any loan made to the provider from a grant to a  
3 State under subsection (b) for such purpose, exceed  
4 100 percent of the provider's costs for such purchase  
5 or enhanced utilization (taking into account costs for  
6 training, implementation, and maintenance).

7 “(6) PREFERENCE IN AWARDING GRANTS.—In  
8 awarding grants to eligible entities under this sub-  
9 section, the Secretary shall give preference to each  
10 of the following types of applicants:

11 “(A) An entity that is located in a frontier  
12 or other rural underserved area as determined  
13 by the Secretary.

14 “(B) An entity that will link, to the extent  
15 practicable, the qualified health information  
16 system to a local or regional health information  
17 plan or plans.

18 “(C) A rural health care provider that is a  
19 nonprofit hospital or a Federally qualified  
20 health center.

21 “(D) A rural health care provider that is  
22 an individual practice or group practice.

23 “(b) AUTHORIZATION OF APPROPRIATIONS.—

24 “(1) IN GENERAL.—For the purpose of car-  
25 rying out this section, there are authorized to be ap-

1       appropriated \$20,000,000 for fiscal year 2010,  
2       \$30,000,000 for fiscal year 2011, and such sums as  
3       may be necessary, but not to exceed \$30,000,000 for  
4       each of fiscal years 2012 through 2014.

5           “(2) AVAILABILITY.—Amounts appropriated  
6       under paragraph (1) shall remain available through  
7       fiscal year 2013.

8       “(c) DEFINITIONS.—In this section:

9           “(1) FEDERALLY QUALIFIED HEALTH CEN-  
10      TER.—The term ‘Federally qualified health center’  
11      has the meaning given that term in section  
12      1861(aa)(4) of the Social Security Act (42 U.S.C.  
13      1395x(aa)(4)).

14          “(2) GROUP PRACTICE.—The term ‘group prac-  
15      tice’ has the meaning given that term in section  
16      1877(h)(4) of the Social Security Act (42 U.S.C.  
17      1395nn(h)(4)).

18          “(3) HEALTH CARE PROVIDER.—The term  
19      ‘health care provider’ means a hospital, skilled nurs-  
20      ing facility, home health agency (as defined in sub-  
21      section (o) of section 1861 of the Social Security  
22      Act, 42 U.S.C. 1395x), health care clinic, rural  
23      health clinic, Federally qualified health center, group  
24      practice, a pharmacist, a pharmacy, a laboratory, a  
25      physician (as defined in subsection (r) of such sec-

tion), a practitioner (as defined in section 1842(b)(18)(CC) of such Act, 42 U.S.C. 1395u(b)(18)(CC)), a health facility operated by or pursuant to a contract with the Indian Health Service, and any other category of facility or clinician determined appropriate by the Secretary.

“(4) HEALTH INFORMATION; INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The terms ‘health information’ and ‘individually identifiable health information’ have the meanings given those terms in paragraphs (4) and (6), respectively, of section 1171 of the Social Security Act (42 U.S.C. 1320d).

“(5) LABORATORY.—The term ‘laboratory’ has the meaning given that term in section 353.

“(6) PHARMACIST.—The term ‘pharmacist’ has the meaning given that term in section 804(a)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(a)(2)).

“(7) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term ‘qualified health information technology’ means a system or components of health information technology that meet any applicable core interoperability guidelines (endorsed under applicable provisions of law) when in use or that use inter-

1 face software that allows for interoperability in ac-  
2 cordance with such guidelines.

3 “(8) RURAL AREA.—The term ‘rural area’ has  
4 the meaning given such term for purposes of section  
5 1886(d)(2)(D) of the Social Security Act (42 U.S.C.  
6 1395ww(d)(2)(D)).

7 “(9) RURAL HEALTH CARE PROVIDER.—The  
8 term ‘rural health care provider’ means a health  
9 care provider that is located in a rural area.”.

10 **SEC. 312. SURVEY QUESTIONS ON SEXUAL ORIENTATION**  
11 **AND GENDER IDENTITY.**

12 The Secretary of Health and Human Services, acting  
13 through the Director of the Centers for Disease Control  
14 and Prevention, shall include in the National Health Inter-  
15 view Survey (or any successor survey) questions to identify  
16 the sexual orientation and gender identity of individuals  
17 participating in the survey.

18 **SEC. 313. DISAGGREGATION OF COMPARATIVE EFFECTIVE-**  
19 **NESS RESEARCH DATA.**

20 The Secretary of Health and Human Services may  
21 not make available any Federal funds for comparative ef-  
22 fectiveness health care research, unless the recipient of the  
23 funds agrees to ensure that the research data will be  
24 disaggregated by race, ethnicity, and gender to detect and  
25 measure differences among subpopulations.

# **TITLE IV—ACCOUNTABILITY AND EVALUATION**

## **Subtitle A—General Provisions**

### **SEC. 401. FEDERAL AGENCY PLAN TO ELIMINATE DISPARITIES AND IMPROVE THE HEALTH OF MINORITY POPULATIONS.**

(a) IN GENERAL.—Not later than September 1, 2010, each Federal health agency shall develop and implement a national strategic action plan to eliminate disparities on the basis of race, ethnicity, and primary language and improve the health and health care of minority populations, through programs relevant to the mission of the agency.

(b) PUBLICATION.—Each action plan described in paragraph (1) shall—

(1) be publicly reported in draft form for public review and comment;

(2) include a response to the review and comment described in paragraph (1) in the final plan;

(3) include the agency response to the 2002 Institute of Medicine report, *Unequal Treatment—Confronting Racial and Ethnic Disparities in Healthcare*;

(4) respond to data and analyses presented in the National Healthcare Disparities Report and the

1 National Healthcare Quality Report published annu-  
2 ally by the Agency for Healthcare Research and  
3 Quality;

4 (5) demonstrate progress in meeting the  
5 Healthy People 2010 objectives; and

6 (6) be updated, including progress reports, for  
7 inclusion in an annual report to Congress.

8 **SEC. 402. PROHIBITION ON DISCRIMINATION IN FEDERAL**  
9 **ASSISTED HEALTH CARE SERVICES AND RE-**  
10 **SEARCH PROGRAMS ON THE BASIS OF SEX,**  
11 **RACE, COLOR, NATIONAL ORIGIN, SEXUAL**  
12 **ORIENTATION, GENDER IDENTITY, OR DIS-**  
13 **ABILITY STATUS.**

14 No person in the United States shall, on the basis  
15 of sex, race, color, national origin, sexual orientation, gen-  
16 der identity, or disability status, be excluded from partici-  
17 pation in, be denied the benefits of, or be subjected to dis-  
18 crimination under any health care service or research pro-  
19 gram or activity receiving Federal financial assistance.

20 **SEC. 403. ACCOUNTABILITY WITHIN THE DEPARTMENT OF**  
21 **HEALTH AND HUMAN SERVICES.**

22 Title XXXI of the Public Health Service Act, as  
23 amended by titles II and III of this Act, is further amend-  
24 ed by adding at the end the following:

## **“Subtitle C—Strengthening Accountability**

### **“SEC. 3141. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

“(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

“(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

“(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled ‘Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity’ (September, 1999) in conjunction with the reports by the Institute of Medicine entitled ‘Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care’, ‘Crossing the Quality



1 Chasm: A New Health System for the 21st Cen-  
2 tury’, and ‘In the Nation’s Compelling Interest: En-  
3 suring Diversity in the Health Care Workforce’ and  
4 other related reports by the Institute of Medicine.  
5 This plan shall be publicly disclosed for review and  
6 comment and the final plan shall address any com-  
7 ments or concerns that are received by the Office.

8 “(2) Investigative and enforcement actions  
9 against intentional discrimination and policies and  
10 practices that have a disparate impact on minorities.

11 “(3) The review of racial, ethnic, and primary  
12 language health data collected by Federal health  
13 agencies to assess health care disparities related to  
14 intentional discrimination and policies and practices  
15 that have a disparate impact on minorities.

16 “(4) Outreach and education activities relating  
17 to compliance with title VI of the Civil Rights Act.

18 “(5) The provision of technical assistance for  
19 health entities to facilitate compliance with title VI  
20 of the Civil Rights Act.

21 “(6) Coordination and oversight of activities of  
22 the civil rights compliance offices established under  
23 section 3142.

24 “(7) Ensuring compliance with the 1997 Office  
25 of Management and Budget Standards for Maintain-

1 ing, Collecting, and Presenting Federal Data on  
2 Race, Ethnicity and the available language stand-  
3 ards.

4 “(c) FUNDING AND STAFF.—The Secretary shall en-  
5 sure the effectiveness of the Office of Health Disparities  
6 by ensuring that the Office is provided with—

7 “(1) adequate funding to enable the Office to  
8 carry out its duties under this section; and

9 “(2) staff with expertise in—

10 “(A) epidemiology;

11 “(B) statistics;

12 “(C) health quality assurance;

13 “(D) minority health and health dispari-  
14 ties;

15 “(E) cultural and linguistic competency;

16 and

17 “(F) civil rights.

18 “(d) REPORT.—Not later than December 31, 2010,  
19 and annually thereafter, the Secretary, in collaboration  
20 with the Director of the Office for Civil Rights and the  
21 Director of the Office of Minority Health, shall submit a  
22 report to the Committee on Health, Education, Labor, and  
23 Pensions of the Senate and the Committee on Energy and  
24 Commerce of the House of Representatives that in-  
25 cludes—

1           “(1) the number of cases filed, broken down by  
2       category;

3           “(2) the number of cases investigated and  
4       closed by the office;

5           “(3) the outcomes of cases investigated;

6           “(4) the staffing levels of the office including  
7       staff credentials;

8           “(5) the number of other lingering and emerg-  
9       ing cases in which civil rights inequities can be dem-  
10      onstrated; and

11          “(6) the number of cases remaining open and  
12      an explanation for their open status.

13      “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
14   are authorized to be appropriated to carry out this section,  
15   such sums as may be necessary for each of fiscal years  
16   2010 through 2015.

17   **“SEC. 3142. ESTABLISHMENT OF HEALTH PROGRAM OF-**  
18                   **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**  
19                   **HEALTH AND HUMAN SERVICES AGENCIES.**

20      “(a) IN GENERAL.—The Secretary shall establish  
21   civil rights compliance offices in each agency within the  
22   Department of Health and Human Services that admin-  
23   isters health programs.

24      “(b) PURPOSE OF OFFICES.—Each office established  
25   under subsection (a) shall ensure that recipients of Fed-

1 eral financial assistance under Federal health programs  
2 administer their programs, services, and activities in a  
3 manner that—

4 “(1) does not discriminate, either intentionally  
5 or in effect, on the basis of race, national origin, lan-  
6 guage, ethnicity, sex, age, or disability; and

7 “(2) promotes the reduction and elimination of  
8 disparities in health and health care based on race,  
9 national origin, language, ethnicity, sex, age, and  
10 disability.

11 “(c) POWERS AND DUTIES.—The offices established  
12 in subsection (a) shall have the following powers and du-  
13 ties:

14 “(1) The establishment of compliance and pro-  
15 gram participation standards for recipients of Fed-  
16 eral financial assistance under each program admin-  
17 istered by an agency within the Department of  
18 Health and Human Services including the establish-  
19 ment of disparity reduction standards to encompass  
20 disparities in health and health care related to race,  
21 national origin, language, ethnicity, sex, age, and  
22 disability.

23 “(2) The development and implementation of  
24 program-specific guidelines that interpret and apply  
25 Department of Health and Human Services guid-

1       ance under title VI of the Civil Rights Act of 1964  
2       to each Federal health program administered by the  
3       agency.

4               “(3) The development of a disparity-reduction  
5       impact analysis methodology that shall be applied to  
6       every rule issued by the agency and published as  
7       part of the formal rulemaking process under sections  
8       555, 556, and 557 of title 5, United States Code.

9               “(4) Oversight of data collection, analysis, and  
10      publication requirements for all recipients of Federal  
11      financial assistance under each Federal health pro-  
12      gram administered by the agency, and compliance  
13      with the 1997 Office of Management and Budget  
14      Standards for Maintaining, Collecting, and Pre-  
15      senting Federal Data on Race and Ethnicity and the  
16      available language standards.

17              “(5) The conduct of publicly available studies  
18      regarding discrimination within Federal health pro-  
19      grams administered by the agency as well as dis-  
20      parity reduction initiatives by recipients of Federal  
21      financial assistance under Federal health programs.

22              “(6) Annual reports to the Committee on  
23      Health, Education, Labor, and Pensions and the  
24      Committee on Finance of the Senate and the Com-  
25      mittee on Energy and Commerce and the Committee

1 on Ways and Means of the House of Representatives  
2 on the progress in reducing disparities in health and  
3 health care through the Federal programs adminis-  
4 tered by the agency.

5 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS  
6 IN THE DEPARTMENT OF JUSTICE.—

7 “(1) DEPARTMENT OF HEALTH AND HUMAN  
8 SERVICES.—The Office for Civil Rights in the De-  
9 partment of Health and Human Services shall pro-  
10 vide standard-setting and compliance review inves-  
11 tigation support services to the Civil Rights Compli-  
12 ance Office for each agency.

13 “(2) DEPARTMENT OF JUSTICE.—The Office  
14 for Civil Rights in the Department of Justice shall  
15 continue to maintain the power to institute formal  
16 proceedings when an agency Office for Civil Rights  
17 determines that a recipient of Federal financial as-  
18 sistance is not in compliance with the disparity re-  
19 duction standards of the agency.

20 “(e) DEFINITION.—In this section, the term ‘Federal  
21 health programs’ mean programs—

22 “(1) under the Social Security Act (42 U.S.C.  
23 301 et seq.) that pay for health care and services;  
24 and

1           “(2) under this Act that provide Federal finan-  
2           cial assistance for health care, biomedical research,  
3           health services research, and programs designed to  
4           improve the public’s health.”.

5   **SEC. 404. OFFICE OF MINORITY HEALTH.**

6           Section 1707 of the Public Health Service Act (42  
7   U.S.C. 300u-6) is amended—

8           (1) by striking subsection (b) and inserting the  
9           following:

10          “(b) DUTIES.—With respect to improving the health  
11   of racial and ethnic minority groups, the Secretary, acting  
12   through the Deputy Assistant Secretary for Minority  
13   Health (in this section referred to as the ‘Deputy Assist-  
14   ant Secretary’), shall carry out the following:

15           “(1) Establish, implement, monitor, and evalu-  
16   ate short-range and long-range goals and objectives  
17   and oversee all other activities within the Public  
18   Health Service that relate to disease prevention,  
19   health promotion, service delivery, and research con-  
20   cerning minority groups. The heads of each of the  
21   agencies of the Service shall consult with the Deputy  
22   Assistant Secretary to ensure the coordination of  
23   such activities.

24           “(2) Oversee all activities within the Depart-  
25   ment of Health and Human Services that relate to

1       reducing or eliminating disparities in health and  
2       health care in racial and ethnic minority populations  
3       and in rural and underserved communities, including  
4       coordinating—

5               “(A) the design of programs, support for  
6               programs, and the evaluation of programs;

7               “(B) the monitoring of trends in health  
8               and health care;

9               “(C) research efforts;

10              “(D) the training of health providers; and

11              “(E) information and education programs  
12              and campaigns.

13              “(3) Enter into interagency and intra-agency  
14              agreements with other agencies of the Public Health  
15              Service.

16              “(4) Ensure that the Federal health agencies  
17              and the National Center for Health Statistics collect  
18              data on the health status and health care of each  
19              minority group, using at a minimum the categories  
20              specified in the 1997 OMB Standards for Maintain-  
21              ing, Collecting, and Presenting Federal Data on  
22              Race and Ethnicity as required under subtitle B and  
23              available language standards.

24              “(5) Provide technical assistance to States,  
25              local agencies, territories, Indian tribes, and entities



1 for activities relating to the elimination of racial and  
2 ethnic disparities in health and health care.

3 “(6) Support a national minority health re-  
4 source center to carry out the following:

5 “(A) Facilitate the exchange of informa-  
6 tion regarding matters relating to health infor-  
7 mation, health promotion and wellness, preven-  
8 tive health services, clinical trials, health infor-  
9 mation technology, and education in the appro-  
10 priate use of health services.

11 “(B) Facilitate timely access to culturally  
12 and linguistically appropriate information.

13 “(C) Assist in the analysis of such infor-  
14 mation.

15 “(D) Provide technical assistance with re-  
16 spect to the exchange of such information (in-  
17 cluding facilitating the development of materials  
18 for such technical assistance).

19 “(7) Carry out programs to improve access to  
20 health care services for individuals with limited  
21 English proficiency, including developing and car-  
22 rying out programs to provide bilingual or interpre-  
23 tive services through the development and support of  
24 the Robert T. Matsui Center for Cultural and Lin-

1       guistic Competence in Health Care as provided for  
2       in section 3103.

3               “(8) Carry out programs to improve access to  
4       health care services and to improve the quality of  
5       health care services for individuals with low func-  
6       tional health literacy. As used in the preceding sen-  
7       tence, the term ‘functional health literacy’ means the  
8       ability to obtain, process, and understand basic  
9       health information and services needed to make ap-  
10      propriate health decisions.

11              “(9) Advise in matters related to the develop-  
12      ment, implementation, and evaluation of health pro-  
13      fessions education on decreasing disparities in health  
14      care outcomes, with focus on cultural competency as  
15      a method of eliminating disparities in health and  
16      health care in racial and ethnic minority popu-  
17      lations.

18              “(10) Assist health care professionals, commu-  
19      nity and advocacy organizations, academic centers  
20      and public health departments in the design and im-  
21      plementation of programs that will improve the qual-  
22      ity of health outcomes by strengthening the pro-  
23      vider-patient relationship.”;

24              (2) by redesignating subsections (f) through (h)  
25      as subsections (g) through (i), respectively;

1           (3) by inserting after subsection (d) the fol-  
 2       lowing:

3       “(f) PREPARATION OF HEALTH PROFESSIONALS TO  
 4       PROVIDE HEALTH CARE TO MINORITY POPULATIONS.—  
 5       The Secretary, in collaboration with the Director of the  
 6       Bureau of Health Professions and the Deputy Assistant  
 7       Secretary for Minority Health, shall require that health  
 8       professional schools that receive Federal funds train fu-  
 9       ture health professionals to provide culturally and linguis-  
 10      tically appropriate health care to diverse populations.”;  
 11      and

12           (4) by striking subsection (i) (as so redesign-  
 13      nated) and inserting the following:

14      “(i) AUTHORIZATION OF APPROPRIATIONS.—For the  
 15      purpose of carrying out this section, there are authorized  
 16      to be appropriated \$100,000,000 for fiscal year 2010, and  
 17      such sums as may be necessary for each of fiscal years  
 18      2011 through 2015.”.

19      **SEC. 405. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**  
 20                                      **ICE AS AN AGENCY OF THE PUBLIC HEALTH**  
 21                                      **SERVICE.**

22      (a) ESTABLISHMENT.—

23           (1) IN GENERAL.—In order to more effectively  
 24      and efficiently carry out the responsibilities, authori-  
 25      ties, and functions of the United States to provide

1 health care services to Indians and Indian tribes, as  
2 are or may be hereafter provided by Federal statute  
3 or treaties, there is established within the Public  
4 Health Service of the Department of Health and  
5 Human Services the Indian Health Service.

6 (2) ASSISTANT SECRETARY OF INDIAN  
7 HEALTH.—The Service shall be administered by an  
8 Assistant Secretary of Indian Health, who shall be  
9 appointed by the President, by and with the advice  
10 and consent of the Senate. The Assistant Secretary  
11 shall report to the Secretary. Effective with respect  
12 to an individual appointed by the President, by and  
13 with the advice and consent of the Senate the term  
14 of service of the Assistant Secretary shall be 4 years.  
15 An Assistant Secretary may serve more than 1 term.

16 (b) AGENCY.—The Service shall be an agency within  
17 the Public Health Service of the Department, and shall  
18 not be an office, component, or unit of any other agency  
19 of the Department.

20 (c) FUNCTIONS AND DUTIES.—The Secretary shall  
21 carry out through the Assistant Secretary of the Service—

22 (1) all functions which were, on the day before  
23 the date of enactment of the Indian Health Care  
24 Amendments of 1988, carried out by or under the

1 direction of the individual serving as Director of the  
2 Service on such day;

3 (2) all functions of the Secretary relating to the  
4 maintenance and operation of hospital and health fa-  
5 cilities for Indians and the planning for, and provi-  
6 sion and utilization of, health services for Indians;

7 (3) all health programs under which health care  
8 is provided to Indians based upon their status as In-  
9 dians which are administered by the Secretary, in-  
10 cluding programs under—

11 (A) the Indian Health Care Improvement  
12 Act;

13 (B) the Act of November 2, 1921 (25  
14 U.S.C. 13);

15 (C) the Act of August 5, 1954 (42 U.S.C.  
16 2001 et seq.);

17 (D) the Act of August 16, 1957 (42  
18 U.S.C. 2005 et seq.);

19 (E) the Indian Self-Determination Act (25  
20 U.S.C. 450f et seq.); and

21 (F) title XXXI of the Public Health Serv-  
22 ice Act, as added by this Act; and

23 (4) all scholarship and loan functions carried  
24 out under title I of the Indian Health Care Improve-  
25 ment Act.

1 (d) AUTHORITY.—

2 (1) IN GENERAL.—The Secretary, acting  
3 through the Assistant Secretary, shall have the au-  
4 thority—

5 (A) except to the extent provided for in  
6 paragraph (2), to appoint and compensate em-  
7 ployees for the Service in accordance with title  
8 5, United States Code;

9 (B) to enter into contracts for the procure-  
10 ment of goods and services to carry out the  
11 functions of the Service; and

12 (C) to manage, expend, and obligate all  
13 funds appropriated for the Service.

14 (2) PERSONNEL ACTIONS.—Notwithstanding  
15 any other provision of law, the provisions of section  
16 12 of the Act of June 18, 1934 (48 Stat. 986; 25  
17 U.S.C. 472), shall apply to all personnel actions  
18 taken with respect to new positions created within  
19 the Service as a result of its establishment under  
20 subsection (a).

21 (e) RATE OF PAY.—

22 (1) POSITIONS AT LEVEL IV.—Section 5315 of  
23 title 5, United States Code, is amended by striking  
24 the following: “Assistant Secretaries of Health and

1 Human Services (6).” and inserting “Assistant Sec-  
2 retaries of Health and Human Services (7).”.

3 (2) POSITIONS AT LEVEL V.—Section 5316 of  
4 such title is amended by striking the following: “Di-  
5 rector, Indian Health Service, Department of Health  
6 and Human Services.”.

7 (f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN  
8 HEALTH.—Section 601 of the Indian Health Care Im-  
9 provement Act (25 U.S.C. 1661) is amended in subsection  
10 (a)—

11 (1) by inserting “(1)” after “(a)”;

12 (2) in the second sentence of paragraph (1), as  
13 so designated, by striking “a Director,” and insert-  
14 ing “the Assistant Secretary for Indian Health,”;

15 (3) by striking the third sentence of paragraph  
16 (1), as so designated, and all that follows through  
17 the end of the subsection (a) of such section and in-  
18 serting the following: “The Assistant Secretary for  
19 Indian Health shall carry out the duties specified in  
20 paragraph (2).”; and

21 (4) by adding after paragraph (1) the following:

22 “(2) The Assistant Secretary for Indian Health  
23 shall—

1           “(A) report directly to the secretary con-  
2           cerning all policy and budget-related matters  
3           affecting Indian health;

4           “(B) collaborate with the Assistant Sec-  
5           retary for Health concerning appropriate mat-  
6           ters of Indian health that affect the agencies of  
7           the Public Health Service;

8           “(C) advise each Assistant Secretary of the  
9           Department of Health and Human Services  
10          concerning matters of Indian health with re-  
11          spect to which that Assistant Secretary has au-  
12          thority and responsibility;

13          “(D) advise the heads of other agencies  
14          and programs of the Department of Health and  
15          Human Services concerning matters of Indian  
16          health with respect to which those heads have  
17          authority and responsibility; and

18          “(E) coordinate the activities of the De-  
19          partment of Health and Human Services con-  
20          cerning matters of Indian health.”.

21          (g) CONTINUED SERVICE BY INCUMBENT.—The indi-  
22          vidual serving in the position of Director of the Indian  
23          Health Service on the date preceding the date of enact-  
24          ment of this Act may serve as Assistant Secretary for In-



1 dian Health, at the pleasure of the President after the  
2 date of enactment of this Act.

3 (h) CONFORMING AMENDMENTS.—

4 (1) AMENDMENTS TO INDIAN HEALTH CARE IM-  
5 PROVEMENT ACT.—The Indian Health Care Im-  
6 provement Act (25 U.S.C. 1601 et seq.) is amend-  
7 ed—

8 (A) in section 601—

9 (i) in subsection (c), by striking “Di-  
10 rector of the Indian Health Service” both  
11 places it appears and inserting “Assistant  
12 Secretary for Indian Health”; and

13 (ii) in subsection (d), by striking “Di-  
14 rector of the Indian Health Service” and  
15 inserting “Assistant Secretary for Indian  
16 Health”; and

17 (B) in section 816(c)(1), by striking “Di-  
18 rector of the Indian Health Service” and insert-  
19 ing “Assistant Secretary for Indian Health”.

20 (2) AMENDMENTS TO OTHER PROVISIONS OF  
21 LAW.—The following provisions are each amended  
22 by striking “Director of the Indian Health Service”  
23 each place it appears and inserting “Assistant Sec-  
24 retary for Indian Health”:

1 (A) Section 203(a)(1) of the Rehabilitation  
2 Act of 1973 (29 U.S.C. 763(a)(1)).

3 (B) Subsections (b) and (e) of section 518  
4 of the Federal Water Pollution Control Act (33  
5 U.S.C. 1377 (b) and (e)).

6 (C) Section 803B(d)(1) of the Native  
7 American Programs Act of 1974 (42 U.S.C.  
8 2991b-2(d)(1)).

9 (i) REFERENCES.—Reference in any other Federal  
10 law, Executive order, rule, regulation, or delegation of au-  
11 thority, or any document of or relating to the Director  
12 of the Indian Health Service shall be deemed to refer to  
13 the Assistant Secretary for Indian Health.

14 (j) DEFINITIONS.—For purposes of this section, the  
15 definitions contained in section 4 of the Indian Health  
16 Care Improvement Act shall apply.

17 **SEC. 406. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MI-**  
18 **NORITY HEALTH WITHIN AGENCIES OF THE**  
19 **PUBLIC HEALTH SERVICE.**

20 Title XVII of the Public Health Service Act (42  
21 U.S.C. 300u et seq.) is amended by inserting after section  
22 1707 the following section:

23 “INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN  
24 PUBLIC HEALTH SERVICE

25 “SEC. 1707A.

1       “(a) IN GENERAL.—The head of each agency speci-  
2       fied in subsection (b)(1) shall establish within the agency  
3       an office to be known as the Office of Minority Health.  
4       Each such Office shall be headed by a director, who shall  
5       be appointed by the head of the agency within which the  
6       Office is established, and who shall report directly to the  
7       head of the agency. The head of such agency shall carry  
8       out this section (as this section relates to the agency) act-  
9       ing through such Director.

10       “(b) SPECIFIED AGENCIES.—

11               “(1) IN GENERAL.—The agencies referred to in  
12       subsection (a) are the following:

13                       “(A) The Centers for Disease Control and  
14       Prevention.

15                       “(B) The Health Resources and Services  
16       Administration.

17                       “(C) The Substance Abuse and Mental  
18       Health Services Administration.

19                       “(D) The Administration on Aging.

20       “(c) COMPOSITION.—The head of each specified  
21       agency shall ensure that the officers and employees of the  
22       minority health office of the agency are, collectively, expe-  
23       rienced in carrying out community-based health programs  
24       for each of the various racial and ethnic minority groups

1 that are present in significant numbers in the United  
2 States.

3 “(d) DUTIES.—Each Director of a minority health of-  
4 fice shall establish and monitor the programs of the speci-  
5 fied agency of such office in order to carry out the fol-  
6 lowing:

7 “(1) Determine the extent to which the pur-  
8 poses of the programs are being carried out with re-  
9 spect to racial and ethnic minority groups;

10 “(2) Determine the extent to which members of  
11 such groups are represented among the Federal offi-  
12 cers and employees who administer the programs;  
13 and

14 “(3) Make recommendations to the head of  
15 such agency on carrying out the programs with re-  
16 spect to such groups. In the case of programs that  
17 provide services, such recommendations shall include  
18 recommendations toward ensuring that—

19 “(A) the services are equitably delivered  
20 with respect to racial and ethnic minority  
21 groups;

22 “(B) the programs provide the services in  
23 the language and cultural context that is most  
24 appropriate for the individuals for whom the  
25 services are intended; and

1           “(C) the programs utilize racial and ethnic  
2           minority community-based organizations to de-  
3           liver services.

4           “(e) BIENNIAL REPORTS TO SECRETARY.—The head  
5 of each specified agency shall submit to the Secretary for  
6 inclusion in each biennial report describing—

7           “(1) the extent to which the minority health of-  
8           fice of the agency employs individuals who are mem-  
9           bers of racial and ethnic minority groups, including  
10          a specification by minority group of the number of  
11          such individuals employed by such office.

12          “(f) FUNDING.—

13          “(1) ALLOCATIONS.—Of the amounts appro-  
14          priated for a specified agency for a fiscal year, the  
15          Secretary must designate an appropriate amount of  
16          funds for the purpose of carrying out activities  
17          under this section through the minority health office  
18          of the agency. In reserving an amount under the  
19          preceding sentence for a minority health office for a  
20          fiscal year, the Secretary shall reduce, by substan-  
21          tially the same percentage, the amount that other-  
22          wise would be available for each of the programs of  
23          the designated agency involved.

24          “(2) AVAILABILITY OF FUNDS FOR STAFF-  
25          ING.—The purposes for which amounts made avail-

1       able under paragraph may be expended by a minor-  
2       ity health office include the costs of employing staff  
3       for such office.”.

4   **SEC. 407. OFFICE OF MINORITY HEALTH AT THE CENTERS**  
5       **FOR MEDICARE & MEDICAID SERVICES.**

6       (a) IN GENERAL.—Not later than 60 days after the  
7       date of enactment of this Act, the Secretary of Health and  
8       Human Services shall establish within the Centers for  
9       Medicare & Medicaid Services an Office of Minority  
10      Health (referred to in this section as the “Office”).

11      (b) DUTIES.—The Office shall be responsible for the  
12      coordination and facilitation of activities of the Centers  
13      for Medicare & Medicaid Services to improve minority  
14      health and health care and to reduce racial and ethnic dis-  
15      parities in health and health care, which shall include—

16              (1) creating a strategic plan, which shall be  
17              made available for public review, to improve the  
18              health and health care of Medicare, Medicaid, and  
19              SCHIP beneficiaries;

20              (2) promoting agency-wide policies relating to  
21              health care delivery and financing that could have a  
22              beneficial impact on the health and health care of  
23              minority populations;

1           (3) assisting health plans, hospitals, and other  
2 health entities in providing culturally and linguis-  
3 tically appropriate health care services;

4           (4) increasing awareness and outreach activities  
5 for minority health care consumers and providers  
6 about the causes and remedies for health and health  
7 care disparities;

8           (5) developing grant programs and demonstra-  
9 tion projects to identify, implement and evaluate in-  
10 novative approaches to improving the health and  
11 health care of minority beneficiaries in the Medicare,  
12 Medicaid, and SCHIP programs;

13           (6) considering incentive programs relating to  
14 reimbursement that would reward health entities for  
15 providing quality health care for minority popu-  
16 lations using established benchmarks for quality of  
17 care;

18           (7) collaborating with the compliance office to  
19 ensure compliance with the anti-discrimination provi-  
20 sions under title VI of the Civil Rights Act of 1964;

21           (8) identifying barriers to enrollment in public  
22 programs under the jurisdiction of the Centers for  
23 Medicare & Medicaid Services;

1           (9) monitoring and evaluating on a regular  
2 basis the success of minority health programs and  
3 initiatives;

4           (10) publishing an annual report about the ac-  
5 tivities of the Centers for Medicare & Medicaid Serv-  
6 ices relating to minority health improvement; and

7           (11) other activities determined appropriate by  
8 the Secretary of Health and Human Services.

9       (c) STAFF.—The staff at the Office shall include—

10           (1) one or more individuals with expertise in  
11 minority health and racial and ethnic health dispari-  
12 ties; and

13           (2) one or more individuals with expertise in  
14 health care financing and delivery in underserved  
15 communities.

16       (d) COORDINATION.—In carrying out its duties under  
17 this section, the Office shall coordinate with—

18           (1) the Office of Minority Health in the Office  
19 of the Secretary of Health and Human Services;

20           (2) the National Centers for Minority Health  
21 and Health Disparities in the National Institutes of  
22 Health; and

23           (3) the Office of Minority Health in the Centers  
24 for Disease Control and Prevention.



1 (e) AUTHORIZATION OF APPROPRIATIONS.—For the  
2 purpose of carrying out this section, there are authorized  
3 to be appropriated \$10,000,000 for fiscal year 2010, and  
4 such sums may be necessary for each of fiscal years 2011  
5 through 2016.

6 **SEC. 408. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND**  
7 **DRUG ADMINISTRATION.**

8 Chapter IX of the Federal Food, Drug, and Cosmetic  
9 Act (21 U.S.C. 391 et seq.) is amended by adding at the  
10 end the following:

11 **“SEC. 911. OFFICE OF MINORITY AFFAIRS.**

12 “(a) IN GENERAL.—Not later than 60 days after the  
13 date of enactment of this section, the Secretary shall es-  
14 tablish within the Office of the Commissioner of Food and  
15 Drugs an Office of Minority Affairs (referred to in this  
16 section as the ‘Office’).

17 “(b) DUTIES.—The Office shall be responsible for the  
18 coordination and facilitation of activities of the Food and  
19 Drug Administration to improve minority health and  
20 health care and to reduce racial and ethnic disparities in  
21 health and health care, which shall include—

22 “(1) promoting policies in the development and  
23 review of medical products that reduce racial and  
24 ethnic disparities in health and health care;

1           “(2) encouraging appropriate data collection,  
2           analysis, and dissemination of racial and ethnic dif-  
3           ferences using, at a minimum, the categories de-  
4           scribed in the 1997 Office of Management and  
5           Budget standards, in response to different therapies  
6           in both adult and pediatric populations;

7           “(3) providing, in coordination with other ap-  
8           propriate government agencies, education, training,  
9           and support to increase participation of minority pa-  
10          tients and physicians in clinical trials;

11          “(4) collecting and analyzing data using, at a  
12          minimum, the categories described in the 1997 Of-  
13          fice of Management and Budget standards, on the  
14          number of participants from minority racial and eth-  
15          nic backgrounds in clinical trials used to support  
16          medical product approvals;

17          “(5) the identification of methods to reduce lan-  
18          guage and literacy barriers; and

19          “(6) publishing an annual report about the ac-  
20          tivities of the Food and Drug Administration per-  
21          taining to minority health.

22          “(c) STAFF.—The staff of the Office shall include—

23               “(1) one or more individuals with expertise in  
24               the design and conduct of clinical trials of drugs, bi-  
25               ological products, and medical devices; and

1           “(2) one or more individuals with expertise in  
2           therapeutic classes or disease states for which med-  
3           ical evidence suggests a difference based on race or  
4           ethnicity.

5           “(d) COORDINATION.—In carrying out its duties  
6 under this section, the Office shall coordinate with—

7           “(1) the Office of Minority Health in the Office  
8           of the Secretary of Health and Human Services;

9           “(2) the National Institute for Minority Health  
10          and Health Disparities in the National Institutes of  
11          Health; and

12          “(3) the Office of Minority Health in the Cen-  
13          ters for Disease Control and Prevention.

14          “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
15 purpose of carrying out this section, there are authorized  
16 to be appropriated such sums as may be necessary for  
17 each of the fiscal years 2010 through 2015.”.

18 **SEC. 409. SAFETY AND EFFECTIVENESS OF DRUGS WITH**  
19 **RESPECT TO RACIAL AND ETHNIC BACK-**  
20 **GROUND.**

21          (a) IN GENERAL.—Chapter V of the Federal Food,  
22 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-  
23 ed by adding after section 505D the following:

1 **“SEC. 505E. SAFETY AND EFFECTIVENESS OF DRUGS WITH**  
2 **RESPECT TO RACIAL AND ETHNIC BACK-**  
3 **GROUND.**

4 “(a) PRE-APPROVAL STUDIES.—If there is evidence  
5 that there may be a disparity on the basis of racial or  
6 ethnic background as to the safety or effectiveness of a  
7 drug, then—

8 “(1)(A) the investigations required under sec-  
9 tion 505(b)(1)(A) shall include adequate and well-  
10 controlled investigations of the disparity; or

11 “(B) the evidence required under section 351(a)  
12 of the Public Health Service Act for approval of a  
13 biologics license application for the drug shall in-  
14 clude adequate and well-controlled investigations of  
15 the disparity; and

16 “(2) if the investigations confirm that there is  
17 a disparity, the labeling of the drug shall include ap-  
18 propriate information about the disparity.

19 “(b) POST-MARKET STUDIES.—

20 “(1) IN GENERAL.—If there is evidence that  
21 there may be a disparity on the basis of racial or  
22 ethnic background as to the safety or effectiveness  
23 of a drug for which there is an approved application  
24 under section 505 or a license under section 351 of  
25 the Public Health Service Act, the Secretary may by  
26 order require the holder of the approved application

1 or license to conduct, by a date specified by the Sec-  
2 retary, post-marketing studies to investigate the dis-  
3 parity.

4 “(2) LABELING.—If the Secretary determines  
5 that the post-market studies confirm that there is a  
6 disparity described in paragraph (1), the labeling of  
7 the drug shall include appropriate information about  
8 the disparity.

9 “(3) STUDY DESIGN.—The Secretary may  
10 specify all aspects of study design, including the  
11 number of studies and study participants, in the  
12 order requiring post-market studies of the drug.

13 “(4) MODIFICATIONS OF STUDY DESIGN.—The  
14 Secretary may by order modify any aspect of the  
15 study design as necessary after issuing an order  
16 under paragraph (1).

17 “(5) STUDY RESULTS.—The results from stud-  
18 ies required under paragraph (1) shall be submitted  
19 to the Secretary as supplements to the drug applica-  
20 tion or biological license application.

21 “(c) DISPARITY.—The term ‘evidence that there may  
22 be a disparity on the basis of racial or ethnic background  
23 for adult and pediatric populations as to the safety or ef-  
24 fectiveness of a drug’ includes—

1           “(1) evidence that there is a disparity on the  
2           basis of racial or ethnic background as to safety or  
3           effectiveness of a drug in the same chemical class as  
4           the drug;

5           “(2) evidence that there is a disparity on the  
6           basis of racial or ethnic background in the way the  
7           drug is metabolized; and

8           “(3) other evidence as the Secretary may deter-  
9           mine.

10          “(d) APPLICATIONS UNDER SECTION 505(b)(2) AND  
11          505(j).—

12           “(1) IN GENERAL.—A drug for which an appli-  
13           cation has been submitted or approved under section  
14           505(j) shall not be considered ineligible for approval  
15           under that section or misbranded under section 502  
16           on the basis that the labeling of the drug omits in-  
17           formation relating to a disparity on the basis of ra-  
18           cial or ethnic background as to the safety or effec-  
19           tiveness of the drug, whether derived from investiga-  
20           tions or studies required under this section or de-  
21           rived from other sources, when the omitted informa-  
22           tion is protected by patent or by exclusivity under  
23           clause (iii) or (iv) of section 505(j)(5)(B).

24           “(2) LABELING.—Notwithstanding clauses (iii)  
25           and (iv) of section 505(j)(5)(B), the Secretary may

1       require that the labeling of a drug approved under  
2       section 505(j) that omits information relating to a  
3       disparity on the basis of racial or ethnic background  
4       as to the safety or effectiveness of the drug include  
5       a statement of any appropriate contraindications,  
6       warnings, or precautions related to the disparity  
7       that the Secretary considers necessary.”.

8       (b) ENFORCEMENT.—Section 502 of the Federal  
9       Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amend-  
10      ed by adding at the end the following:

11       “(aa) If it is a drug and the holder of the approved  
12      application under section 505 or license under section 351  
13      of the Public Health Service Act for the drug has failed  
14      to complete the investigations or studies, or comply with  
15      any other requirement, of section 505E.”.

16       (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the  
17      Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)  
18      is amended by adding after “are required” the following:  
19      “, including supplements required under section 505E”.

20      **SEC. 410. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

21       (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF  
22      ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of  
23      1983 (42 U.S.C. 1975a) is amended—  
24

1           (1) in paragraph (1)(B), by striking “and” at  
2     the end;

3           (2) in paragraph (2), in the matter after and  
4     below subparagraph (D), by striking the period and  
5     inserting “; and”; and

6           (3) by adding at the end the following:

7           “(3) shall, with respect to activities carried out  
8     in health care and correctional facilities toward the  
9     goal of eliminating health disparities between the  
10    general population and members of racial or ethnic  
11    minority groups, coordinate such activities of—

12           “(A) the Office for Civil Rights within the  
13    Department of Justice;

14           “(B) the Office of Justice Programs within  
15    the Department of Justice;

16           “(C) the Office for Civil Rights within the  
17    Department of Health and Human Services;  
18    and

19           “(D) the Office of Minority Health within  
20    the Department of Health and Human Services  
21    (headed by the Deputy Assistant Secretary for  
22    Minority Health).”.

23       (b) AUTHORIZATION OF APPROPRIATIONS.—Section  
24    5 of the Civil Rights Commission Act of 1983 (42 U.S.C.  
25    1975c) is amended by striking the first sentence and in-



1 setting the following: “For the purpose of carrying out  
2 this Act, there are authorized to be appropriated  
3 \$30,000,000 for fiscal year 2010, and such sums as may  
4 be necessary for each of the fiscal years 2011 through  
5 2015.”.

6 **SEC. 411. SENSE OF CONGRESS CONCERNING FULL FUND-**  
7 **ING OF ACTIVITIES TO ELIMINATE RACIAL**  
8 **AND ETHNIC HEALTH DISPARITIES.**

9 (a) FINDINGS.—Congress makes the following find-  
10 ings:

11 (1) The health status of the American populace  
12 is declining and the United States currently ranks  
13 below most industrialized nations in health status  
14 measured by longevity, sickness, and mortality.

15 (2) Racial and ethnic minority populations tend  
16 have the poorest health status and face substantial  
17 cultural, social, and economic barriers to obtaining  
18 quality health care.

19 (3) Efforts to improve minority health have  
20 been limited by inadequate resources (funding, staff-  
21 ing, and stewardship) and accountability.

22 (b) SENSE OF CONGRESS.—It is the sense of Con-  
23 gress that—

24 (1) funding should be doubled by fiscal year  
25 2010 for the National Institute for Minority Health

1 Disparities, the Office of Civil Rights in the Depart-  
2 ment of Health and Human Services, the National  
3 Institute of Nursing Research, and the Office of Mi-  
4 nority Health;

5 (2) adequate funding by fiscal year 2010, and  
6 subsequent funding increases, should be provided for  
7 health professions training programs, the Racial and  
8 Ethnic Approaches to Community Health (REACH)  
9 at the Center for Disease Control and Prevention,  
10 the Minority HIV/AIDS Initiative, and the Excel-  
11 lence Centers to Eliminate Ethnic/Racial Disparities  
12 (EXCEED) Program at the Agency for Healthcare  
13 Research and Quality;

14 (3) current and newly created health disparity  
15 elimination incentives, programs, agencies, and de-  
16 partments under this Act (and the amendments  
17 made by this Act) should receive adequate staffing  
18 and funding by fiscal year 2010; and

19 (4) stewardship and accountability should be  
20 provided to Congress and the President for measur-  
21 able and sustainable progress toward health dis-  
22 parity elimination.

1 **SEC. 412. GUIDELINES FOR DISEASE SCREENING FOR MI-**  
2 **NORITY PATIENTS.**

3 (a) IN GENERAL.—The Secretary, acting through the  
4 Director of the Agency for Healthcare Research and Qual-  
5 ity, shall convene a series of meetings to develop guidelines  
6 for disease screening for minority patient populations  
7 which have a higher than average risk for many chronic  
8 diseases and cancers.

9 (b) PARTICIPANTS.—In convening meetings under  
10 subsection (a), the Secretary shall ensure that meeting  
11 participants include representatives of—

- 12 (1) professional societies and associations;
- 13 (2) minority health organizations;
- 14 (3) health care researchers and providers, in-  
15 cluding those with expertise in minority health;
- 16 (4) Federal health agencies, including the Of-  
17 fice of Minority Health, the National Center on Mi-  
18 nority Health and Health Disparities, and the Na-  
19 tional Institutes of Health; and
- 20 (5) other experts determined appropriate by the  
21 Secretary.

22 (c) DISEASES.—Screening guidelines for minority  
23 populations shall be developed under subsection (a) for—

- 24 (1) hypertension;
- 25 (2) hypercholesterolemia;
- 26 (3) diabetes;

- 1 (4) cardiovascular disease;
- 2 (5) cancers, including breast, prostate, colon,
- 3 cervical, and lung cancer;
- 4 (6) asthma;
- 5 (7) diabetes;
- 6 (8) kidney diseases;
- 7 (9) eye diseases and disorders, including glau-
- 8 coma;
- 9 (10) HIV/AIDS and sexually transmitted dis-
- 10 eases;
- 11 (11) uterine fibroids;
- 12 (12) autoimmune disease;
- 13 (13) mental health conditions;
- 14 (14) dental health conditions and oral diseases;
- 15 (15) environmental and related health illnesses
- 16 and conditions;
- 17 (16) Sickle cell disease;
- 18 (17) violence and injury prevention and control;
- 19 (18) genetic and related conditions;
- 20 (19) heart disease and stroke;
- 21 (20) tuberculosis;
- 22 (21) chronic obstructive pulmonary disease; and
- 23 (22) other diseases determined appropriate by
- 24 the Secretary.

1 (d) DISSEMINATION.—Not later than 24 months  
 2 after the date of enactment of this title, the Secretary  
 3 shall publish and disseminate to health care provider orga-  
 4 nizations the guidelines developed under subsection (a).

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
 6 are authorized to be appropriated to carry out this section,  
 7 sums as may be necessary for each of fiscal years 2010  
 8 through 2015.

9 **SEC. 413. NATIONAL INSTITUTE FOR MINORITY HEALTH**  
 10 **AND HEALTH DISPARITIES.**

11 (a) REDESIGNATION.—

12 (1) IN GENERAL.—Title IV of the Public  
 13 Health Service Act (42 U.S.C. 281 et seq.) is  
 14 amended—

15 (A) in section 401(b)(24), by striking “Na-  
 16 tional Center on Minority Health and Health  
 17 Disparities” and inserting “National Institute  
 18 for Minority Health and Health Disparities”;  
 19 and

20 (B) in subpart 6 of part E—

21 (i) in the subpart heading, by striking  
 22 “Center” and inserting “Institute”;

23 (ii) in the headings of sections 485E  
 24 and 485H, by striking “**CENTER**” and in-  
 25 serting “**INSTITUTE**”; and

1 (iii) by striking (other than in section  
2 485E(i)(1)) the term “Center” each place  
3 it appears and inserting “Institute”.

4 (2) REFERENCES.—Any reference in any law,  
5 map, regulation, document, paper, or other record of  
6 the United States to the National Center on Minor-  
7 ity Health and Health Disparities shall be deemed to  
8 be a reference to the National Institute for Minority  
9 Health and Health Disparities.

10 (b) DUTIES; AUTHORITIES; FUNDING.—Section  
11 485E of the Public Health Service Act (42 U.S.C. 287c–  
12 31) is amended—

13 (1) by amending subsection (e) to read as fol-  
14 lows:

15 “(e) DUTIES OF THE DIRECTOR.—

16 “(1) INTERAGENCY COORDINATION OF MINOR-  
17 ITY HEALTH AND HEALTH DISPARITY ACTIVITIES.—

18 With respect to minority health and health dispari-  
19 ties, the Director of the Institute shall plan, coordi-  
20 nate, and evaluate research and other activities con-  
21 ducted or supported by the institutes and centers of  
22 the National Institutes of Health. In carrying out  
23 the preceding sentence, the Director of the Institute  
24 shall evaluate the minority health and health dis-  
25 parity activities of each of such institutes and cen-

1       ters and shall provide for the periodic reevaluation  
2       of such activities. Such institutes and centers shall  
3       be responsible for providing information to the Insti-  
4       tute, including data on clinical trials funded or con-  
5       ducted by these institutes and centers.

6               “(2) CONSULTATIONS.—The Director of the In-  
7       stitute shall carry out this subpart (including devel-  
8       oping and revising the plan and budget required by  
9       subsection (f) in consultation with the heads of the  
10      institutes and centers of the National Institutes of  
11      Health, the advisory councils of such institutes and  
12      centers, and the advisory council established pursu-  
13      ant to subsection (j).

14              “(3) COORDINATION OF ACTIVITIES.—The Di-  
15      rector of the Institute—

16                      “(A) shall act as the primary Federal offi-  
17                      cial with responsibility for coordinating all re-  
18                      search and activities conducted or supported by  
19                      the National Institutes of Health on minority or  
20                      other health disparities;

21                      “(B) shall represent the health disparities  
22                      research program of the National Institutes of  
23                      Health, including the minority health and other  
24                      health disparities research program, at all rel-

1           evant executive branch task forces, committees,  
2           and planning activities; and

3           “(C) shall maintain communications with  
4           all relevant agencies of the Public Health Serv-  
5           ice, including the Indian Health Service, and  
6           various other departments and agencies of the  
7           Federal Government to ensure the timely trans-  
8           mission of information concerning advances in  
9           minority health disparities research and other  
10          health disparities research among these various  
11          agencies for dissemination to affected commu-  
12          nities and health care providers.”;

13          (2) by amending subsection (f) to read as fol-  
14          lows:

15          “(f) STRATEGIC PLAN.—

16                 “(1) IN GENERAL.—Subject to the provisions of  
17                 this section and other applicable law, the Director of  
18                 the Institute, in consultation with the Director of  
19                 NIH, the Directors of the other institutes and cen-  
20                 ters of the National Institutes of Health, and the  
21                 advisory council established pursuant to subsection  
22                 (j), shall—

23                         “(A) annually review and revise a strategic  
24                         plan (referred to in this section as ‘the plan’)  
25                         and budget for the conduct and support of all



1 minority health disparity research and other  
2 health disparity research activities of the insti-  
3 tutes and centers of the National Institutes of  
4 Health that include time-based targeted objec-  
5 tives with measurable outcomes and assure that  
6 the annual review and revision of the plan uses  
7 an established trans-National Institutes of  
8 Health process subject to timely review, ap-  
9 proval, and dissemination;

10 “(B) ensure that the plan and budget es-  
11 tablish priorities among the health disparities  
12 research activities that such agencies are au-  
13 thorized to carry out;

14 “(C) ensure that the plan and budget es-  
15 tablish objectives regarding such activities, de-  
16 scribe the means for achieving the objectives,  
17 and designate the date by which the objectives  
18 are expected to be achieved;

19 “(D) ensure that all amounts appropriated  
20 for such activities are expended in accordance  
21 with the plan and budget;

22 “(E) annually submit to Congress a report  
23 on the progress made with respect to the plan;  
24 and

1           “(F) create and implement a plan for the  
2           systemic review of research activities supported  
3           by the National Institutes of Health that are  
4           within the mission of both the Institute and  
5           other institutes and centers of the National In-  
6           stitutes of Health, including by establishing  
7           mechanisms for—

8                   “(i) tracking minority health and  
9                   health disparity research conducted within  
10                  the institutes and centers assessing the ap-  
11                  propriateness of this research with regard  
12                  to the overall goals and objectives of the  
13                  plan;

14                  “(ii) the early identification of appli-  
15                  cations and proposals for grants, contracts,  
16                  and cooperative agreements supporting ex-  
17                  tramural training, research, and develop-  
18                  ment, that are submitted to the institutes  
19                  and centers that are within the mission of  
20                  the Institute;

21                  “(iii) providing the Institute with the  
22                  written descriptions and scientific peer re-  
23                  view results of such applications and pro-  
24                  posals;

1                   “(iv) enabling the institutes and cen-  
2                   ters to consult with the Director of the In-  
3                   stitute prior to final approval of such ap-  
4                   plications and proposals; and

5                   “(v) reporting to the Director of the  
6                   Institute all such applications and pro-  
7                   posals that are approved for funding by  
8                   the institutes and centers.

9                   “(2) CERTAIN COMPONENTS OF PLAN AND  
10                  BUDGET.—With respect to health disparities re-  
11                  search activities of the agencies of the National In-  
12                  stitutes of Health, the Director of the Institute shall  
13                  ensure that the plan and budget under paragraph  
14                  (1) provide for—

15                   “(A) basic research and applied research,  
16                   including research and development with re-  
17                   spect to products;

18                   “(B) research that is conducted by the  
19                   agencies;

20                   “(C) research that is supported by the  
21                   agencies;

22                   “(D) proposals developed pursuant to so-  
23                   licitations by the agencies and for proposals de-  
24                   veloped independently of such solicitations; and

1           “(E) behavioral research and social  
2           sciences research, which may include cultural  
3           and linguistic research in each of the agencies.

4           “(3) MINORITY HEALTH DISPARITIES RE-  
5           SEARCH.—The plan and budget under paragraph (1)  
6           shall include a separate statement of the plan and  
7           budget for minority health disparities research.”;

8           (3) by amending subsection (h) to read as fol-  
9           lows:

10          “(h) RESEARCH ENDOWMENTS.—

11           “(1) IN GENERAL.—The Director of the Insti-  
12           tute shall carry out a program to facilitate minority  
13           health and health disparities research and other  
14           health disparities research by providing research en-  
15           dowments at—

16           “(A) centers of excellence under section  
17           736; and

18           “(B) centers of excellence under section  
19           485F.

20           “(2) ELIGIBILITY.—The Director of the Insti-  
21           tute shall provide for a research endowment under  
22           paragraph (1) only if the institution involved meets  
23           the following conditions:

24           “(A) The institution does not have an en-  
25           dowment that is worth in excess of an amount

1 equal to 50 percent of the national average of  
2 endowment funds at institutions that conduct  
3 similar biomedical research or training of health  
4 professionals.

5 “(B) The application of the institution  
6 under paragraph (1) regarding a research en-  
7 dowment has been recommended pursuant to  
8 technical and scientific peer review and has  
9 been approved by the advisory council estab-  
10 lished pursuant to subsection (j).

11 “(C) The institution at any time was  
12 deemed to be eligible to receive a grant under  
13 section 736 and at any time received a research  
14 endowment under paragraph (1).”; and  
15 (4) by adding at the end the following:

16 “(k) FUNDING.—

17 “(1) FULL FUNDING BUDGET.—

18 “(A) IN GENERAL.—With respect to a fis-  
19 cal year, the Director of the Institute shall pre-  
20 pare and submit directly to the President, for  
21 review and transmittal to Congress, a budget  
22 estimate for carrying out the plan for the fiscal  
23 year, after reasonable opportunity for comment  
24 (but without change) by the Secretary, the Di-  
25 rector of the National Institutes of Health, the

1 directors of the other institutes and centers of  
2 the National Institutes of Health, and the advi-  
3 sory council established pursuant to subsection  
4 (j). The budget estimate shall include an esti-  
5 mate of the number and type of personnel  
6 needs for the Institute.

7 “(B) AMOUNTS NECESSARY.—The budget  
8 estimate submitted under subparagraph (A)  
9 shall estimate the amounts necessary for the in-  
10 stitutes and centers of the National Institutes  
11 of Health to carry out all minority health and  
12 health disparities activities determined by the  
13 Director of the Institute to be appropriate,  
14 without regard to the probability that such  
15 amounts will be appropriated.

16 “(2) ALTERNATE BUDGETS.—

17 “(A) IN GENERAL.—With respect to a fis-  
18 cal year, the Director of the Institute shall pre-  
19 pare and submit to the Secretary and the Di-  
20 rector of the National Institutes of Health the  
21 budget estimates described in subparagraph (B)  
22 for carrying out the plan for the fiscal year.  
23 The Secretary and such Director shall consider  
24 each of such estimates in making recommenda-

1           tions to the President regarding a budget for  
2           the plan for such year.

3           “(B) DESCRIPTION.—With respect to the  
4           fiscal year involved, the budget estimates re-  
5           ferred to in subparagraph (A) for the plan are  
6           as follows:

7                   “(i) The budget estimate submitted  
8                   under paragraph (1).

9                   “(ii) A budget estimate developed on  
10                  the assumption that the amounts appro-  
11                  priated will be sufficient only for—

12                           “(I) continuing the conduct by  
13                           the institutes and centers of the Na-  
14                           tional Institutes of Health of existing  
15                           minority health and health disparity  
16                           activities (if approved for continu-  
17                           ation), and continuing the support of  
18                           such activities by the institutes and  
19                           centers in the case of projects or pro-  
20                           grams for which the institutes or cen-  
21                           ters have made a commitment of con-  
22                           tinued support; and

23                           “(II) carrying out activities that  
24                           are in addition to activities specified  
25                           in subclause (I), only for which the

1 Director determines there is the most  
2 substantial need.

3 “(iii) Such other budget estimates as  
4 the Director of the Institute determines to  
5 be appropriate.”.

6 **SEC. 414. IOM REPORT ON LGBT HEALTH DISPARITIES.**

7 The Secretary of Health and Human Services shall  
8 enter into an agreement with the Institute of Medicine to  
9 prepare and submit to the Congress a report on—

10 (1) health and health care disparities experi-  
11 enced by the lesbian, gay, bisexual, and transgender  
12 communities; and

13 (2) the unique health and health care chal-  
14 lenges experienced by such communities.

15 **Subtitle B—Improving**  
16 **Environmental Justice**

17 **SEC. 421. CODIFICATION OF EXECUTIVE ORDER 12898.**

18 (a) IN GENERAL.—The President of the United  
19 States is authorized and directed to execute, administer,  
20 and enforce as a matter of Federal law the provisions of  
21 Executive Order 12898, dated February 11, 1994 (“Fed-  
22 eral Actions To Address Environmental Justice In Minor-  
23 ity Populations and Low-Income Populations”), with such  
24 modifications as are provided in this section.



1 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For  
2 purposes of carrying out the provisions of Executive Order  
3 12898, the following definitions shall apply:

4 (1) The term “environmental justice” means  
5 the fair treatment and meaningful involvement of all  
6 people regardless of race, color, national origin, edu-  
7 cational level, or income with respect to the develop-  
8 ment, implementation, and enforcement of environ-  
9 mental laws and regulations in order to ensure  
10 that—

11 (A) minority and low-income communities  
12 have access to public information relating to  
13 human health and environmental planning, reg-  
14 ulations, and enforcement; and

15 (B) no minority or low-income population  
16 is forced to shoulder a disproportionate burden  
17 of the negative human health and environ-  
18 mental impacts of pollution or other environ-  
19 mental hazard.

20 (2) The term “fair treatment” means policies  
21 and practices that ensure that no group of people,  
22 including racial, ethnic, or socioeconomic groups  
23 bear disproportionately high and adverse human  
24 health or environmental effects resulting from Fed-  
25 eral agency programs, policies, and activities.

1 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—

2 The provisions of section 6–609 of Executive Order 12898

3 shall not apply for purposes of this Act.

4 **SEC. 422. IMPLEMENTATION OF RECOMMENDATIONS BY**  
5 **ENVIRONMENTAL PROTECTION AGENCY.**

6 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The

7 Administrator of the Environmental Protection Agency

8 shall, as promptly as practicable, carry out each of the

9 following recommendations of the Inspector General of the

10 agency as set forth in Report No. 2006–P–00034 entitled

11 “EPA needs to conduct environmental justice reviews of

12 its programs, policies and activities”:

13 (1) The recommendation that the Agency’s pro-

14 gram and regional offices identify which programs,

15 policies, and activities need environmental justice re-

16 views and require these offices to establish a plan to

17 complete the necessary reviews.

18 (2) The recommendation that the Administrator

19 of the Agency ensure that these reviews determine

20 whether the programs, policies, and activities may

21 have a disproportionately high and adverse health or

22 environmental impact on minority and low-income

23 populations.

24 (3) The recommendation that each program

25 and regional office develop specific environmental

1 justice review guidance for conducting environmental  
2 justice reviews.

3 (4) The recommendation that the Administrator  
4 designate a responsible office to compile results of  
5 environmental justice reviews and recommend appro-  
6 priate actions.

7 (b) GAO RECOMMENDATIONS.—In developing rules  
8 under laws administered by the Environmental Protection  
9 Agency, the Administrator of the Agency shall, as prompt-  
10 ly as practicable, carry out each of the following rec-  
11 ommendations of the Comptroller General of the United  
12 States as set forth in GAO Report numbered GAO–05–  
13 289 entitled “EPA Should Devote More Attention to En-  
14 vironmental Justice when Developing Clean Air Rules”:

15 (1) The recommendation that the Administrator  
16 ensure that workgroups involved in developing a rule  
17 devote attention to environmental justice while draft-  
18 ing and finalizing the rule.

19 (2) The recommendation that the Administrator  
20 enhance the ability of such workgroups to identify  
21 potential environmental justice issues through such  
22 steps as providing workgroup members with guid-  
23 ance and training to helping them identify potential  
24 environmental justice problems and involving envi-

1       ronmental justice coordinators in the workgroups  
2       when appropriate.

3               (3) The recommendation that the Administrator  
4       improve assessments of potential environmental jus-  
5       tice impacts in economic reviews by identifying the  
6       data and developing the modeling techniques needed  
7       to assess such impacts.

8               (4) The recommendation that the Administrator  
9       direct appropriate Agency officers and employees to  
10      respond fully when feasible to public comments on  
11      environmental justice, including improving the Agen-  
12      cy's explanation of the basis for its conclusions, to-  
13      gether with supporting data.

14      (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-  
15      ministrator of the Environmental Protection Agency shall,  
16      as promptly as practicable, carry out each of the following  
17      recommendations of the Inspector General of the Agency  
18      as set forth in the report entitled “EPA Needs to Consist-  
19      ently Implement the Intent of the Executive Order on En-  
20      vironmental Justice” (Report No. 2004–P–00007):

21              (1) The recommendation that the Agency clear-  
22      ly define the mission of the Office of Environmental  
23      Justice (OEJ) and provide Agency staff with an un-  
24      derstanding of the roles and responsibilities of the  
25      Office.

1           (2) The recommendation that the Agency estab-  
2       lish (through issuing guidance or a policy statement  
3       from the Administrator) specific time frames for the  
4       development of definitions, goals, and measurements  
5       regarding environmental justice and provide the re-  
6       gions and program offices a standard and consistent  
7       definition for a minority and low-income community,  
8       with instructions on how the Agency will implement  
9       and operationalize environmental justice into the  
10      Agency’s daily activities.

11          (3) The recommendation that the Agency en-  
12      sure the comprehensive training program currently  
13      under development includes standard and consistent  
14      definitions of the key environmental justice concepts  
15      (such as “low-income”, “minority”, and “dispropor-  
16      tionately impacted”) and instructions for implemen-  
17      tation of those concepts.

18      (d) REPORT.—The Administrator shall submit an ini-  
19      tial report to Congress within 6 months after the enact-  
20      ment of this Act regarding the Administrator’s strategy  
21      for implementing the recommendations referred to in sub-  
22      sections (a), (b), and (c). Thereafter, the Administrator  
23      shall provide semi-annual reports to Congress regarding  
24      the Administrator’s progress in implementing such rec-  
25      ommendations and modifying the Administrator’s emer-

1 gency management procedures to incorporate environ-  
2 mental justice in the Agency’s Incident Command Struc-  
3 ture (in accordance with the December 18, 2006, letter  
4 from the Deputy Administrator to the Acting Inspector  
5 General of the agency).

6 **SEC. 423. GRANT PROGRAM.**

7 (a) DEFINITIONS.—In this section:

8 (1) DIRECTOR.—The term “Director” means  
9 the Director of the Centers for Disease Control and  
10 Prevention, acting in collaboration with the Adminis-  
11 trator of the Environmental Protection Agency and  
12 the Director of the National Institute of Environ-  
13 mental Health Sciences.

14 (2) ELIGIBLE ENTITY.—The term “eligible enti-  
15 ty” means a State or local community that—

16 (A) bears a disproportionate burden of ex-  
17 posure to environmental health hazards;

18 (B) has established a coalition—

19 (i) with not less than 1 community-  
20 based organization; and

21 (ii) with not less than 1—

22 (I) public health entity;

23 (II) health care provider organi-  
24 zation; or

1 (III) academic institution, includ-  
2 ing any minority-serving institution  
3 (including an Hispanic-serving institu-  
4 tion, a historically Black college or  
5 university, and a tribal college or uni-  
6 versity);

7 (C) ensures planned activities and funding  
8 streams are coordinated to improve community  
9 health; and

10 (D) submits an application in accordance  
11 with subsection (c).

12 (b) ESTABLISHMENT.—The Director shall establish a  
13 grant program under which eligible entities shall receive  
14 grants to conduct environmental health improvement ac-  
15 tivities.

16 (c) APPLICATION.—To receive a grant under this sec-  
17 tion, an eligible entity shall submit an application to the  
18 Director at such time, in such manner, and accompanied  
19 by such information as the Director may require.

20 (d) COOPERATIVE AGREEMENTS.—An eligible entity  
21 may use a grant under this section—

22 (1) to promote environmental health; and

23 (2) to address environmental health disparities.

24 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

1           (1) IN GENERAL.—The Director shall award  
2           grants to eligible entities at the 2 different funding  
3           levels described in this subsection.

4           (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

5           (A) IN GENERAL.—An eligible entity  
6           awarded a grant under this paragraph shall use  
7           the funds to identify environmental health prob-  
8           lems and solutions by—

9                   (i) establishing a planning and  
10                  prioritizing council in accordance with sub-  
11                  paragraph (B); and

12                  (ii) conducting an environmental  
13                  health assessment in accordance with sub-  
14                  paragraph (C).

15           (B) PLANNING AND PRIORITIZING COUN-  
16           CIL.—

17                  (i) IN GENERAL.—A prioritizing and  
18                  planning council established under sub-  
19                  paragraph (A)(i) (referred to in this para-  
20                  graph as a “PPC”) shall assist the envi-  
21                  ronmental health assessment process and  
22                  environmental health promotion activities  
23                  of the eligible entity.

24                  (ii) MEMBERSHIP.—Membership of a  
25                  PPC shall consist of representatives from



1 various organizations within public health,  
2 planning, development, and environmental  
3 services and shall include stakeholders  
4 from vulnerable groups such as children,  
5 the elderly, disabled, and minority ethnic  
6 groups that are often not actively involved  
7 in democratic or decision-making proc-  
8 esses.

9 (iii) DUTIES.—A PPC shall—

10 (I) identify key stakeholders and  
11 engage and coordinate potential part-  
12 ners in the planning process;

13 (II) establish a formal advisory  
14 group to plan for the establishment of  
15 services;

16 (III) conduct an in-depth review  
17 of the nature and extent of the need  
18 for an environmental health assess-  
19 ment, including a local epidemiological  
20 profile, an evaluation of the service  
21 provider capacity of the community,  
22 and a profile of any target popu-  
23 lations; and

24 (IV) define the components of  
25 care and form essential programmatic

1 linkages with related providers in the  
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-  
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry  
6 out an environmental health assessment to  
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The  
9 PPC shall—

10 (I) define the goals of the assess-  
11 ment;

12 (II) generate the environmental  
13 health issue list;

14 (III) analyze issues with a sys-  
15 tems framework;

16 (IV) develop appropriate commu-  
17 nity environmental health indicators;

18 (V) rank the environmental  
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-  
24 ning for the future.

1 (D) EVALUATION.—Each eligible entity  
2 that receives a grant under this paragraph shall  
3 evaluate, report, and disseminate program find-  
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-  
6 tor may provide such technical and other non-  
7 financial assistance to eligible entities as the  
8 Director determines to be necessary.

9 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall  
12 award grants under this paragraph to eli-  
13 gible entities that have already—

14 (I) established broad-based col-  
15 laborative partnerships; and

16 (II) completed environmental as-  
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To  
19 be eligible to receive a grant under this  
20 paragraph, an eligible entity is not re-  
21 quired to have successfully completed a  
22 Level 1 Cooperative Agreement (as de-  
23 scribed in paragraph (2)).

24 (B) USE OF GRANT FUNDS.—An eligible  
25 entity awarded a grant under this paragraph

1 shall use the funds to further activities to carry  
2 out environmental health improvement activi-  
3 ties, including—

4 (i) addressing community environ-  
5 mental health priorities in accordance with  
6 paragraph (2)(C)(ii), including—

7 (I) air quality;

8 (II) water quality;

9 (III) solid waste;

10 (IV) land use;

11 (V) housing;

12 (VI) food safety;

13 (VII) crime;

14 (VIII) injuries; and

15 (IX) healthcare services;

16 (ii) building partnerships between  
17 planning, public health, and other sectors,  
18 to address how the built environment im-  
19 pacts food availability and access and  
20 physical activity to promote healthy behav-  
21 iors and lifestyles and reduce overweight  
22 and obesity, asthma, respiratory condi-  
23 tions, dental, oral and mental health condi-  
24 tions, and related co-morbidities;

1 (iii) establishing programs to ad-  
2 dress—

3 (I) how environmental and social  
4 conditions of work and living choices  
5 influence physical activity and dietary  
6 intake; or

7 (II) how those conditions influ-  
8 ence the concerns and needs of people  
9 who have impaired mobility and use  
10 assistance devices, including wheel-  
11 chairs and lower limb prostheses; and

12 (iv) convening intervention programs  
13 that examine the role of the social environ-  
14 ment in connection with the physical and  
15 chemical environment in—

16 (I) determining access to nutri-  
17 tional food; and

18 (II) improving physical activity to  
19 reduce morbidity and increase quality  
20 of life.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
22 are authorized to be appropriated to carry out this sec-  
23 tion—

24 (1) \$25,000,000 for fiscal year 2010; and

1           (2) such sums as may be necessary for fiscal  
2       years 2011 through 2014.

3   **SEC. 424. ADDITIONAL RESEARCH ON THE RELATIONSHIP**  
4                   **BETWEEN THE BUILT ENVIRONMENT AND**  
5                   **THE HEALTH OF COMMUNITY RESIDENTS.**

6       (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this  
7   section, the term “eligible institution” means a public or  
8   private nonprofit institution that submits to the Secretary  
9   of Health and Human Services (in this section referred  
10   to as the “Secretary”) and the Administrator of the Envi-  
11   ronmental Protection Agency (in this section referred to  
12   as the “Administrator”) an application for a grant under  
13   the grant program authorized under subsection (b)(2) at  
14   such time, in such manner, and containing such agree-  
15   ments, assurances, and information as the Secretary and  
16   Administrator may require.

17       (b) RESEARCH GRANT PROGRAM.—

18           (1) DEFINITION OF HEALTH.—In this section,  
19       the term “health” includes—

20                   (A) levels of physical activity;

21                   (B) consumption of nutritional foods;

22                   (C) rates of crime;

23                   (D) air, water, and soil quality;

24                   (E) risk of injury;

25                   (F) accessibility to healthcare services; and

1 (G) other indicators as determined appro-  
2 priate by the Secretary.

3 (2) GRANTS.—The Secretary, in collaboration  
4 with the Administrator, shall provide grants to eligi-  
5 ble institutions to conduct and coordinate research  
6 on the built environment and its influence on indi-  
7 vidual and population-based health.

8 (3) RESEARCH.—The Secretary shall support  
9 research that—

10 (A) investigates and defines the causal  
11 links between all aspects of the built environ-  
12 ment and the health of residents;

13 (B) examines—

14 (i) the extent of the impact of the  
15 built environment (including the various  
16 characteristics of the built environment) on  
17 the health of residents;

18 (ii) the variance in the health of resi-  
19 dents by—

20 (I) location (such as inner cities,  
21 inner suburbs, and outer suburbs);  
22 and

23 (II) population subgroup (such as  
24 children, the elderly, the disadvan-  
25 tagged); or

1 (iii) the importance of the built envi-  
2 ronment to the total health of residents,  
3 which is the primary variable of interest  
4 from a public health perspective;

5 (C) is used to develop—

6 (i) measures to address health and the  
7 connection of health to the built environ-  
8 ment; and

9 (ii) efforts to link the measures to  
10 travel and health databases; and

11 (D) distinguishes carefully between per-  
12 sonal attitudes and choices and external influ-  
13 ences on observed behavior to determine how  
14 much an observed association between the built  
15 environment and the health of residents, versus  
16 the lifestyle preferences of the people that  
17 choose to live in the neighborhood, reflects the  
18 physical characteristics of the neighborhood;  
19 and

20 (E)(i) identifies or develops effective inter-  
21 vention strategies to promote better health  
22 among residents with a focus on behavioral  
23 interventions and enhancements of the built en-  
24 vironment that promote increased use by resi-  
25 dents; and



1 (ii) in developing the intervention strate-  
 2 gies under clause (i), ensures that the interven-  
 3 tion strategies will reach out to high-risk popu-  
 4 lations, including racial and ethnic minorities  
 5 and low-income urban and rural communities.

6 (4) PRIORITY.—In providing assistance under  
 7 the grant program authorized under paragraph (2),  
 8 the Secretary and the Administrator shall give pri-  
 9 ority to research that incorporates—

10 (A) minority-serving institutions as grant-  
 11 ees;

12 (B) interdisciplinary approaches; or

13 (C) the expertise of the public health,  
 14 physical activity, urban planning, and transpor-  
 15 tation research communities in the United  
 16 States and abroad.

17 **TITLE V—IMPROVEMENT OF**  
 18 **HEALTH CARE SERVICES**  
 19 **Subtitle A—Health Empowerment**  
 20 **Zones**

21 **SEC. 501. SHORT TITLE.**

22 This subtitle may be cited as the “Health Empower-  
 23 ment Zone Act of 2009”.

24 **SEC. 502. FINDINGS.**

25 The Congress finds the following:

1           (1) Numerous studies and reports, including  
2           the National Healthcare Disparities Report and Un-  
3           equal Treatment, the 2002 Institute of Medicine Re-  
4           port, document the extensiveness to which health  
5           disparities exist across the country.

6           (2) These studies have found that, on average,  
7           racial and ethnic minorities are disproportionately  
8           afflicted with chronic and acute conditions—such as  
9           cancer, diabetes, and hypertension—and suffer  
10          worse health outcomes, worse health status, and  
11          higher mortality rates than their White counter-  
12          parts.

13          (3) Several recent studies also show that health  
14          disparities are a function of not only access to health  
15          care, but also the social determinants of health—in-  
16          cluding the environment, the physical structure of  
17          communities, nutrition and food options, educational  
18          attainment, employment, race, ethnicity, geography,  
19          and language preference—that directly and indi-  
20          rectly affect the health, health care, and wellness of  
21          individuals and communities.

22          (4) Integrally involving and fully supporting the  
23          communities most affected by health inequities in  
24          the assessment, planning, launch, and evaluation of  
25          health disparity elimination efforts is among the

1 leading recommendations made to adequately ad-  
2 dress and ultimately reduce health disparities.

3 (5) Recommendations also include supporting  
4 the efforts of community stakeholders from a broad  
5 cross-section—including, but not limited to local  
6 businesses, local departments of commerce, edu-  
7 cation, labor, urban planning, and transportation,  
8 and community-based and other nonprofit organiza-  
9 tions—to find areas of common ground around  
10 health disparity elimination and collaborate to im-  
11 prove the overall health and wellness of a community  
12 and its residents.

13 **SEC. 503. DESIGNATION OF HEALTH EMPOWERMENT**  
14 **ZONES.**

15 (a) IN GENERAL.—At the request of an eligible com-  
16 munity partnership, the Secretary may designate an eligi-  
17 ble area as a health empowerment zone.

18 (b) ELIGIBILITY CRITERIA.—

19 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A  
20 community partnership is eligible to submit a re-  
21 quest under this section if the partnership—

22 (A) demonstrates widespread public sup-  
23 port from key individuals and entities in the eli-  
24 gible area, including State and local govern-  
25 ments, nonprofit organizations, and community

1 and industry leaders, for designation of the eli-  
2 gible area as a health empowerment zone; and

3 (B) includes representatives of—

4 (i) a broad cross section of stake-  
5 holders and residents from communities in  
6 the eligible area experiencing dispropor-  
7 tionate disparities in health status and  
8 health care; and

9 (ii) organizations, facilities, and insti-  
10 tutions that have a history of working  
11 within and serving such communities.

12 (2) ELIGIBLE AREA.—An area is eligible to be  
13 designated as a health empowerment zone under this  
14 section if one or more communities in the area expe-  
15 rience disproportionate disparities in health status  
16 and health care. In determining whether a commu-  
17 nity experiences such disparities, the Secretary shall  
18 consider the data collected by the Department of  
19 Health and Human Services focusing on the fol-  
20 lowing areas:

21 (A) Access to high-quality health services.

22 (B) Arthritis, osteoporosis, and chronic  
23 back conditions.

24 (C) Cancer.

25 (D) Chronic kidney disease.

- 1 (E) Diabetes.
- 2 (F) Injury and violence prevention.
- 3 (G) Maternal, infant, and child health.
- 4 (H) Medical product safety.
- 5 (I) Mental health and mental disorders.
- 6 (J) Nutrition and overweight.
- 7 (K) Disability and secondary conditions.
- 8 (L) Educational and community-based
- 9 health programs.
- 10 (M) Environmental health.
- 11 (N) Family planning.
- 12 (O) Food safety.
- 13 (P) Health communication.
- 14 (Q) Health disease and stroke.
- 15 (R) HIV/AIDS.
- 16 (S) Immunization and infectious diseases.
- 17 (T) Occupational safety and health.
- 18 (U) Oral health.
- 19 (V) Physical activity and fitness.
- 20 (W) Public health infrastructure.
- 21 (X) Respiratory diseases.
- 22 (Y) Sexually transmitted diseases.
- 23 (Z) Substance abuse.
- 24 (AA) Tobacco use.
- 25 (BB) Vision and hearing.

1 (c) PROCEDURE.—

2 (1) REQUEST.—A request under subsection (a)  
3 shall—

4 (A) describe the bounds of the area to be  
5 designated as a health empowerment zone and  
6 the process used to select those bounds;

7 (B) demonstrate that the partnership sub-  
8 mitting the request is an eligible community  
9 partnership described in subsection (b)(1);

10 (C) demonstrate that the area is an eligible  
11 area described in subsection (b)(2);

12 (D) include a comprehensive assessment of  
13 disparities in health status and health care ex-  
14 perience by one or more communities in the  
15 area;

16 (E) set forth—

17 (i) a vision and a set of values for the  
18 area; and

19 (ii) a comprehensive and holistic set of  
20 goals to be achieved in the area through  
21 designation as a health empowerment zone;  
22 and

23 (F) include a strategic plan for achieving  
24 the goals described in subparagraph (E)(ii).

1           (2) APPROVAL.—Not later than 60 days after  
2       the receipt of a request for designation of an area  
3       as a health empowerment zone under this section,  
4       the Secretary shall approve or disapprove the re-  
5       quest.

6       (d) MINIMUM NUMBER.—The Secretary—

7           (1) shall designate not more than 110 health  
8       empowerment zones under this section; and

9           (2) shall designate at least one health empower-  
10      ment zone in each of the several States, the District  
11      of Columbia, and each territory or possession of the  
12      United States.

13   **SEC. 504. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

14       At the request of any organization or entity seeking  
15   to submit a request under section 503(a), the Secretary  
16   shall provide technical assistance, and may award a grant,  
17   to assist such organization or entity—

18           (1) to form an eligible community partnership  
19      described in section 503(b)(1);

20           (2) to complete a health assessment, including  
21      an assessment of health disparities under section  
22      503(c)(1)(D); or

23           (3) to prepare and submit a request, including  
24      a strategic plan, in accordance with section 503.

1 **SEC. 505. BENEFITS OF DESIGNATION.**

2 (a) PRIORITY.—In awarding any competitive grant,  
3 a Federal official shall give priority to any applicant  
4 that—

5 (1) meets the eligibility criteria for the grant;

6 (2) proposes to use the grant for activities in a  
7 health empowerment zone; and

8 (3) demonstrates that such activities will di-  
9 rectly and significantly further the goals of the stra-  
10 tegic plan approved for such zone under section 503.

11 (b) GRANTS FOR INITIAL IMPLEMENTATION OF  
12 STRATEGIC PLAN.—

13 (1) IN GENERAL.—Upon designating an eligible  
14 area as a health empowerment zone at the request  
15 of an eligible community partnership, the Secretary  
16 shall, subject to the availability of appropriations,  
17 make a grant to the community partnership for im-  
18 plementation of the strategic plan for such zone.

19 (2) GRANT PERIOD.—A grant under paragraph  
20 (1) for a health empowerment zone shall be for a pe-  
21 riod of 2 years and may be renewed, except that the  
22 total period of grants under paragraph (1) for such  
23 zone may not exceed 10 years.

24 (3) LIMITATION.—In awarding grants under  
25 this subsection, the Secretary shall not give less pri-  
26 ority to an applicant or reduce the amount of a



1 grant because the Secretary rendered technical as-  
2 sistance or made a grant to the same applicant  
3 under section 504.

4 (4) REPORTING.—The Secretary shall require  
5 each recipient of a grant under this subsection to re-  
6 port to the Secretary not less than every 6 months  
7 on the progress in implementing the strategic plan  
8 for the health empowerment zone.

9 **SEC. 506. DEFINITION.**

10 In this subtitle, the term “Secretary” means the Sec-  
11 retary of Health and Human Services, acting through the  
12 Administrator of the Health Resources and Services Ad-  
13 ministration and the Director of the Office of Minority  
14 Health, and in cooperation with the Director of the Office  
15 of Community Services and the Director of the National  
16 Institute for Minority Health and Health Disparities.

17 **SEC. 507. AUTHORIZATION OF APPROPRIATIONS.**

18 To carry out this subtitle, there is authorized to be  
19 appropriated \$100,000,000 for fiscal year 2010.

1 **Subtitle B—Other Improvements of**  
2 **Health Care Services**

3 **CHAPTER 1—IN GENERAL**

4 **SEC. 511. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
5 **ACT.**

6 Title XXXI of the Public Health Service Act, as  
7 amended by titles II, III, and IV of this Act, is further  
8 amended by adding at the end the following:

9 **“Subtitle D—Reconstruction and**  
10 **Improvement Grants for Public**  
11 **Health Care Facilities Serving**  
12 **Pacific Islanders and the Insu-**  
13 **lar Areas**

14 **“SEC. 3151. GRANT SUPPORT FOR QUALITY IMPROVEMENT**  
15 **INITIATIVES.**

16 “(a) IN GENERAL.—The Secretary, in collaboration  
17 with the Administrator of the Health Resources and Serv-  
18 ices Administration, the Director of the Agency for  
19 Healthcare Research and Quality, and the Administrator  
20 of the Centers for Medicare & Medicaid Services, shall  
21 award grants to eligible entities for the conduct of dem-  
22 onstration projects to improve the quality of and access  
23 to health care.

24 “(b) ELIGIBILITY.—To be eligible to receive a grant  
25 under subsection (a), an entity shall—

1           “(1) be a health center, hospital, health plan,  
2           health system, community clinic. or other health en-  
3           tity determined appropriate by the Secretary—

4                   “(A) that, by legal mandate or explicitly  
5                   adopted mission, provides patients with access  
6                   to services regardless of their ability to pay;

7                   “(B) that provides care or treatment for a  
8                   substantial number of patients who are unin-  
9                   sured, are receiving assistance under a State  
10                  program under title XIX of the Social Security  
11                  Act, or are members of vulnerable populations,  
12                  as determined by the Secretary; and

13                  “(C)(i) with respect to which, not less than  
14                  50 percent of the entity’s patient population is  
15                  made up of racial and ethnic minorities; or

16                  “(ii) that—

17                          “(I) serves a disproportionate percent-  
18                          age of local, minority racial and ethnic pa-  
19                          tients, or that has a patient population, at  
20                          least 50 percent of which is limited English  
21                          proficient; and

22                          “(II) provides an assurance that  
23                          amounts received under the grant will be  
24                          used only to support quality improvement

1 activities in the racial and ethnic popu-  
2 lation served; and

3 “(2) prepare and submit to the Secretary an  
4 application at such time, in such manner, and con-  
5 taining such information as the Secretary may re-  
6 quire.

7 “(c) PRIORITY.—In awarding grants under sub-  
8 section (a), the Secretary shall give priority to applicants  
9 under subsection (b)(2) that—

10 “(1) demonstrate an intent to operate as part  
11 of a health care partnership, network, collaborative,  
12 coalition, or alliance where each member entity con-  
13 tributes to the design, implementation, and evalua-  
14 tion of the proposed intervention; or

15 “(2) intend to use funds to carry out system-  
16 wide changes with respect to health care quality im-  
17 provement, including—

18 “(A) improved systems for data collection  
19 and reporting;

20 “(B) innovative collaborative or similar  
21 processes;

22 “(C) group programs with behavioral or  
23 self-management interventions;

24 “(D) case management services;

1           “(E) physician or patient reminder sys-  
2           tems;

3           “(F) educational interventions; or

4           “(G) other activities determined appro-  
5           priate by the Secretary.

6           “(d) USE OF FUNDS.—An entity shall use amounts  
7           received under a grant under subsection (a) to support  
8           the implementation and evaluation of health care quality  
9           improvement activities or minority health and health care  
10          disparity reduction activities that include—

11          “(1) with respect to health care systems, activi-  
12          ties relating to improving—

13               “(A) patient safety;

14               “(B) timeliness of care;

15               “(C) effectiveness of care;

16               “(D) efficiency of care;

17               “(E) patient centeredness; and

18               “(F) health information technology; and

19          “(2) with respect to patients, activities relating  
20          to—

21               “(A) staying healthy;

22               “(B) getting well;

23               “(C) living with illness or disability; and

24               “(D) coping with end of life issues.

1       “(e) COMMON DATA SYSTEMS.—The Secretary shall  
2 provide financial and other technical assistance to grant-  
3 ees under this section for the development of common data  
4 systems.

5       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
6 are authorized to be appropriated to carry out this section,  
7 such sums as may be necessary for each of fiscal years  
8 2010 through 2015.

9       **“SEC. 3152. CENTERS OF EXCELLENCE.**

10       “(a) IN GENERAL.—The Secretary, acting through  
11 the Administrator of the Health Resources and Services  
12 Administration, shall designate centers of excellence at  
13 public hospitals, and other health systems serving large  
14 numbers of minority patients, that—

15               “(1) meet the requirements of section  
16 3151(b)(1);

17               “(2) demonstrate excellence in providing care to  
18 minority populations; and

19               “(3) demonstrate excellence in reducing dispari-  
20 ties in health and health care.

21       “(b) REQUIREMENTS.—A hospital or health system  
22 that serves as a Center of Excellence under subsection (a)  
23 shall—

24               “(1) design, implement, and evaluate programs  
25 and policies relating to the delivery of care in ra-

1 cially, ethnically, and linguistically diverse popu-  
2 lations;

3 “(2) provide training and technical assistance  
4 to other hospitals and health systems relating to the  
5 provision of quality health care to minority popu-  
6 lations; and

7 “(3) develop activities for graduate or con-  
8 tinuing medical education that institutionalize a  
9 focus on cultural competence training for health care  
10 providers.

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
12 are authorized to be appropriated to carry out this section,  
13 such sums as may be necessary for each of fiscal years  
14 2010 through 2015.

15 **“SEC. 3153. RECONSTRUCTION AND IMPROVEMENT GRANTS**  
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**  
17 **ING PACIFIC ISLANDERS AND THE INSULAR**  
18 **AREAS.**

19 “(a) IN GENERAL.—The Secretary shall provide di-  
20 rect financial assistance to designated health care pro-  
21 viders and community health centers in American Samoa,  
22 Guam, the Commonwealth of the Northern Mariana Is-  
23 lands, the United States Virgin Islands, Puerto Rico, and  
24 Hawaii for the purposes of reconstructing and improving  
25 health care facilities and services.

1       “(b) ELIGIBILITY.—To be eligible to receive direct fi-  
2 nancial assistance under subsection (a), an entity shall be  
3 a public health facility or community health center located  
4 in American Samoa, Guam, or the Commonwealth of the  
5 Northern Mariana Islands, the United States Virgin Is-  
6 lands, Puerto Rico, and Hawaii that—

7               “(1) is owned or operated by—

8                       “(A) the government of American Samoa,  
9                       Guam, or the Commonwealth of the Northern  
10                      Mariana Islands, the United States Virgin Is-  
11                      lands, Puerto Rico, and Hawaii or a unit of  
12                      local government; or

13                     “(B) a nonprofit organization; and

14               “(2)(A) provides care or treatment for a sub-  
15               stantial number of patients who are uninsured, re-  
16               ceiving assistance under a State program under a  
17               title XVIII of the Social Security Act, or a State  
18               program under title XIX of such Act, or who are  
19               members of a vulnerable population, as determined  
20               by the Secretary; or

21               “(B) serves a disproportionate percentage of  
22               local, minority racial and ethnic patients.

23       “(c) REPORT.—Not later than 180 days after the  
24 date of enactment of this title and annually thereafter, the  
25 Secretary shall submit to the Congress and the President



1 a report that includes an assessment of health resources  
2 and facilities serving populations in American Samoa,  
3 Guam, and the Commonwealth of the Northern Mariana  
4 Islands, the United States Virgin Islands, Puerto Rico,  
5 and Hawaii. In preparing such report, the Secretary  
6 shall—

7 “(1) consult with and obtain information on all  
8 health care facilities needs from the entities de-  
9 scribed in subsection (b);

10 “(2) include all amounts of Federal assistance  
11 received by each entity in the preceding fiscal year;

12 “(3) review the total unmet needs of each juris-  
13 diction for health care facilities, including needs for  
14 renovation and expansion of existing facilities; and

15 “(4) include a strategic plan for addressing the  
16 needs of each jurisdiction identified in the report.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
18 are authorized to be appropriated such sums as necessary  
19 to carry out this section.”.

20 **SEC. 512. MEDICAID PAYMENT FOR CERTAIN ALIENS.**

21 (a) MEDICAID.—Section 1903(v) of the Social Secu-  
22 rity Act (42 U.S.C. 1396b(v)) is amended by striking  
23 paragraph (4) and inserting the following:

24 “(4)(A) Notwithstanding sections 401(a), 402(b),  
25 403, and 421 of Public Law 104–193, payment shall be

1 made under this section for care and services that are fur-  
2 nished to individuals, if they who otherwise meet the eligi-  
3 bility requirements for medical assistance under the State  
4 plan approved under this title (other than the requirement  
5 of the receipt of aid or assistance under title IV, supple-  
6 mental security income benefits under title XVI, or a State  
7 supplementary payment), and are—

8 “(i) lawfully present in the United States;

9 “(ii) children under age 21, including optional  
10 targeted low-income children described in section  
11 1905(u)(2)(B); or

12 “(iii) pregnant women during pregnancy (and  
13 during the 60-day period beginning on the last day  
14 of the pregnancy).

15 “(B) No debt shall accrue under an affidavit of sup-  
16 port against any sponsor of such individual on the basis  
17 of provision of medical assistance and the cost of such as-  
18 sistance shall not be considered as an unreimbursed  
19 cost.”.

20 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-  
21 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by striking  
22 subparagraph (H) and inserting the following:

23 “(H) Paragraph (4) of section 1903(v) (re-  
24 lating to individuals who, but for sections  
25 401(a), 403, and 421 of Public Law 104–193

1           would be eligible for medical assistance under  
2           title XXI).”.

3           (c) CONFORMING AMENDMENT.—Section 1137(f) of  
4   such Act (42 U.S.C. 1320b–7(f)) is amended by inserting  
5   “and for medical assistance provided to children and preg-  
6   nant women” before the period at the end.

7   **SEC. 513. MEDICAID PAYMENT PARITY FOR THE TERRI-**  
8                                   **TORIES.**

9           (a) ELIMINATION OF FUNDING LIMITATIONS FOR  
10   PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTH-  
11   ERN MARIANA ISLANDS, AND AMERICAN SAMOA.—

12           (1) IN GENERAL.—Section 1108 of the Social  
13   Security Act (42 U.S.C. 1308) is amended—

14           (A) in subsection (f), in the matter before  
15           paragraph (1), by striking “subsection (g)” and  
16           inserting “subsections (g) and (h)”;

17           (B) in subsection (g)(2), in the matter be-  
18           fore subparagraph (A), by inserting “and sub-  
19           section (h)” after “paragraph (3)”; and

20           (C) by adding at the end the following new  
21           subsection:

22           “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-  
23   TO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN  
24   MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections  
25   (f) and (g) shall not apply to Puerto Rico, the Virgin Is-

1 lands, Guam, the Northern Mariana Islands, and Amer-  
2 ican Samoa for any fiscal year after fiscal year 2009.”.

3 (2) CONFORMING AMENDMENT.—Section  
4 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-  
5 ed by striking paragraph (4).

6 (3) EFFECTIVE DATE.—The amendments made  
7 by this subsection shall apply beginning with fiscal  
8 year 2010.

9 (b) PARITY IN FMAP.—

10 (1) IN GENERAL.—Section 1905(b)(2) of such  
11 Act (42 U.S.C. 1396d(b)(2)) is amended by insert-  
12 ing after “50 per centum” the following: “(except  
13 that, beginning with fiscal year 2012, the Federal  
14 medical assistance percentage for Puerto Rico, the  
15 Virgin Islands, Guam, the Northern Mariana Is-  
16 lands, and American Samoa shall be the Federal  
17 medical assistance percentage determined by the  
18 Secretary in consultation (for the Virgin Islands,  
19 Guam, the Northern Mariana Islands, and American  
20 Samoa) with the Secretary of the Interior)”.

21 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-  
22 standing any other provision of law, during fiscal  
23 years 2010 and 2011, the Federal medical assist-  
24 ance percentage established under section 1905(b) of  
25 the Social Security Act (42 U.S.C. 1396d(b)) for

1 Puerto Rico, the Virgin Islands, Guam, the North-  
2 ern Mariana Islands, and American Samoa shall be  
3 the highest such Federal medical assistance percent-  
4 age applicable to any of the 50 States or the District  
5 of Columbia for the fiscal year involved, taking into  
6 account the application of subsections (a) and (b)(1)  
7 of 5001 of division B of the American Recovery and  
8 Reinvestment Act of 2009 (Public Law 111–5) to  
9 such States and District for calendar quarters dur-  
10 ing such fiscal years for which such subsections  
11 apply respectively.

12 (3) PER CAPITA INCOME DATA.—

13 (A) REPORT TO CONGRESS.—Not later  
14 than October 1, 2010, the Secretary of Health  
15 and Human Services shall submit to Congress  
16 a report that describes the per capita income  
17 data used to promulgate the Federal medical  
18 assistance percentage in the territories and how  
19 such data differ from the per capita income  
20 data used to promulgate Federal medical assist-  
21 ance percentages for the 50 States and the Dis-  
22 trict of Columbia. The report should include  
23 recommendations on how the Federal medical  
24 assistance percentages can be calculated for the

1 territories to ensure parity with the 50 States  
2 and the District of Columbia.

3 (B) APPLICATION.—Section 1101(a)(8)(B)  
4 of the Social Security Act (42 U.S.C.  
5 1308(a)(8)(B)) is amended—

6 (i) by striking “(other than Puerto  
7 Rico, the Virgin Islands, and Guam)” and  
8 inserting “(including Puerto Rico, the Vir-  
9 gin Islands, Guam, the Northern Mariana  
10 Islands, and American Samoa)”; and

11 (ii) by inserting “(or, if such satisfac-  
12 tory data are not available in the case of  
13 the Virgin Islands, Guam, the Northern  
14 Mariana Islands, or American Samoa, sat-  
15 isfactory data available from the Depart-  
16 ment of the Interior for the same period,  
17 or if such satisfactory data are not avail-  
18 able in the case of Puerto Rico, satisfac-  
19 tory data available from the government of  
20 the Commonwealth of Puerto Rico for the  
21 same period)” after “Department of Com-  
22 merce”.

23 (4) RELATION TO AMERICAN RECOVERY AND  
24 REINVESTMENT ACT OF 2009.—For any period and  
25 territory in which the provisions of this subsection

1       apply to a territory, the provisions of section  
2       5001(b)(2) of division B of the American Recovery  
3       and Reinvestment Act of 2009 (Public Law 111–5)  
4       shall not apply (except as otherwise specifically pro-  
5       vided in paragraph (2)).

6   **SEC. 514. EXTENSION OF MEDICARE SECONDARY PAYER.**

7       (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-  
8       cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-  
9       ed—

10               (1) in the last sentence, by inserting “, and be-  
11       fore January 1, 2010” after “prior to such date”;  
12       and

13               (2) by adding at the end the following new sen-  
14       tence: “Effective for items and services furnished on  
15       or after January 1, 2010 (with respect to periods  
16       beginning on or after the date that is 42 months  
17       prior to such date), clauses (i) and (ii) shall be ap-  
18       plied by substituting ‘42-month’ for ‘12-month’ each  
19       place it appears in the first sentence.”.

20       (b) EFFECTIVE DATE.—The amendments made by  
21       this subsection shall take effect on the date of enactment  
22       of this Act. For purposes of determining an individual’s  
23       status under section 1862(b)(1)(C) of the Social Security  
24       Act (42 U.S.C. 1395y(b)(1)(C)), as amended by para-  
25       graph (1), an individual who is within the coordinating

1 period as of the date of enactment of this Act shall have  
2 that period extended to the full 42 months described in  
3 the last sentence of such section, as added by the amend-  
4 ment made by paragraph (1)(B).

5 **SEC. 515. BORDER HEALTH GRANTS.**

6 (a) ELIGIBLE ENTITY DEFINED.—In this section,  
7 the term “eligible entity” means a State, public institution  
8 of higher education, local government, tribal government,  
9 nonprofit health organization, community health center, or  
10 community clinic receiving assistance under section 330  
11 of the Public Health Service Act (42 U.S.C. 254b), that  
12 is located in the border area.

13 (b) AUTHORIZATION.—From funds appropriated  
14 under subsection (f), the Secretary of Health and Human  
15 Services (in this section referred to as the “Secretary”),  
16 acting through the United States members of the United  
17 States-Mexico Border Health Commission, shall award  
18 grants to eligible entities to address priorities and rec-  
19 ommendations to improve the health of border area resi-  
20 dents that are established by—

- 21 (1) the United States members of the United  
22 States-Mexico Border Health Commission;  
23 (2) the State border health offices; and  
24 (3) the Secretary.



1       (c) APPLICATION.—An eligible entity that desires a  
2 grant under subsection (b) shall submit an application to  
3 the Secretary at such time, in such manner, and con-  
4 taining such information as the Secretary may require.

5       (d) USE OF FUNDS.—An eligible entity that receives  
6 a grant under subsection (b) shall use the grant funds  
7 for—

8           (1) programs relating to—

9               (A) maternal and child health;

10              (B) primary care and preventative health;

11              (C) public health and public health infra-  
12 structure;

13              (D) health education and promotion;

14              (E) oral health;

15              (F) mental and behavioral health;

16              (G) substance abuse;

17              (H) health conditions that have a high  
18 prevalence in the border area;

19              (I) medical and health services research;

20              (J) workforce training and development;

21              (K) community health workers or  
22 promotoras;

23              (L) health care infrastructure problems in  
24 the border area (including planning and con-  
25 struction grants);

1 (M) health disparities in the border area;

2 (N) environmental health; and

3 (O) outreach and enrollment services with

4 respect to Federal programs (including pro-

5 grams authorized under titles XIX and XXI of

6 the Social Security Act (42 U.S.C. 1396 and

7 1397aa)); and

8 (2) other programs determined appropriate by

9 the Secretary.

10 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-

11 vided to an eligible entity awarded a grant under sub-

12 section (b) shall be used to supplement and not supplant

13 other funds available to the eligible entity to carry out the

14 activities described in subsection (d).

15 (f) AUTHORIZATION OF APPROPRIATIONS.—There

16 are authorized to be appropriated to carry out this section,

17 \$200,000,000 for fiscal year 2010, and such sums as may

18 be necessary for each succeeding fiscal year.

19 **SEC. 516. CANCER PREVENTION AND TREATMENT DEM-**

20 **ONSTRATION FOR ETHNIC AND RACIAL MI-**

21 **NORITIES.**

22 (a) DEMONSTRATION.—

23 (1) IN GENERAL.—The Secretary of Health and

24 Human Services (in this section referred to as the

25 “Secretary”) shall conduct demonstration projects

(in this section referred to as “demonstration projects”) for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears, prostate cancer screenings, and CT scans for lung cancer among target individuals; and

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term “target individual” means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service

1 Act (42 U.S.C. 300u–6) who is entitled to benefits  
2 under part A, and enrolled under part B, of title  
3 XVIII of the Social Security Act.

4 (b) PROGRAM DESIGN.—

5 (1) INITIAL DESIGN.—Not later than 1 year  
6 after the date of the enactment of this Act, the Sec-  
7 retary shall evaluate best practices in the private  
8 sector, community programs, and academic research  
9 of methods that reduce disparities among individuals  
10 of racial and ethnic minority groups in the preven-  
11 tion and treatment of cancer and shall design the  
12 demonstration projects based on such evaluation.

13 (2) NUMBER AND PROJECT AREAS.—Not later  
14 than 2 years after the date of the enactment of this  
15 Act, the Secretary shall implement at least nine  
16 demonstration projects, including the following:

17 (A) Two projects for each of the four fol-  
18 lowing major racial and ethnic minority groups:

19 (i) American Indians and Alaska Na-  
20 tives, Eskimos and Aleuts.

21 (ii) Asian Americans.

22 (iii) Blacks/African Americans.

23 (iv) Hispanic/Latino Americans.

24 (v) Native Hawaiians and other Pa-  
25 cific Islanders.

1           The two projects must target different ethnic  
2           subpopulations.

3           (B) One project within the Pacific Islands  
4           or United States insular areas.

5           (C) At least one project each in a rural  
6           area and inner-city area.

7           (3) EXPANSION OF PROJECTS; IMPLEMENTA-  
8           TION OF DEMONSTRATION PROJECT RESULTS.—If  
9           the initial report under subsection (c) contains an  
10          evaluation that demonstration projects—

11           (A) reduce expenditures under the Medi-  
12           care program under title XVIII of the Social  
13           Security Act; or

14           (B) do not increase expenditures under the  
15           Medicare program and reduce racial and ethnic  
16           health disparities in the quality of health care  
17           services provided to target individuals and in-  
18           crease satisfaction of beneficiaries and health  
19           care providers;

20          the Secretary shall continue the existing demonstra-  
21          tion projects and may expand the number of dem-  
22          onstration projects.

23          (c) REPORT TO CONGRESS.—

24           (1) IN GENERAL.—Not later than 2 years after  
25          the date the Secretary implements the initial dem-

1        onstration projects, and biannually thereafter, the  
2        Secretary shall submit to Congress a report regard-  
3        ing the demonstration projects.

4            (2) CONTENTS OF REPORT.—Each report under  
5        paragraph (1) shall include the following:

6            (A) A description of the demonstration  
7        projects.

8            (B) An evaluation of—

9                (i) the cost-effectiveness of the dem-  
10        onstration projects;

11                (ii) the quality of the health care serv-  
12        ices provided to target individuals under  
13        the demonstration projects; and

14                (iii) beneficiary and health care pro-  
15        vider satisfaction under the demonstration  
16        projects.

17            (C) Any other information regarding the  
18        demonstration projects that the Secretary de-  
19        termines to be appropriate.

20        (d) WAIVER AUTHORITY.—The Secretary shall waive  
21        compliance with the requirements of title XVIII of the So-  
22        cial Security Act to such extent and for such period as  
23        the Secretary determines is necessary to conduct dem-  
24        onstration projects.

1 **SEC. 517. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**  
2 **IOBS IN WOMEN AND CHILDREN.**

3 Part P of title III of the Public Health Service Act  
4 (42 U.S.C. 280g et seq.) is amended—

5 (1) by redesignating the second and third sec-  
6 tions 399R (added by Public Laws 110–373 and  
7 110–374) as sections 399S and 399T, respectively;  
8 and

9 (2) by adding at the end the following:

10 **“SEC. 399U. GRANTS TO PROMOTE POSITIVE HEALTH BE-**  
11 **HAVIORS IN WOMEN AND CHILDREN.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, in col-  
13 laboration with the Director of the Centers for Disease  
14 Control and Prevention and other Federal officials deter-  
15 mined appropriate by the Secretary, is authorized to  
16 award grants to eligible entities to promote positive health  
17 behaviors for women and children in target populations,  
18 especially racial and ethnic minority women and children  
19 in medically underserved communities.

20 “(b) USE OF FUNDS.—Grants awarded pursuant to  
21 subsection (a) may be used to support community health  
22 workers—

23 “(1) to educate and provide outreach regarding  
24 enrollment in health insurance including the State  
25 Children’s Health Insurance Program under title  
26 XXI of the Social Security Act, Medicare under title

1 XVIII of such Act, and Medicaid under title XIX of  
2 such Act;

3 “(2) to educate, guide, and provide outreach in  
4 a community setting regarding health problems prev-  
5 alent among women and children and especially  
6 among racial and ethnic minority women and chil-  
7 dren;

8 “(3) to educate, guide, and provide experiential  
9 learning opportunities that target behavioral risk  
10 factors including—

11 “(A) poor nutrition;

12 “(B) physical inactivity;

13 “(C) being overweight or obese;

14 “(D) tobacco use;

15 “(E) alcohol and substance use;

16 “(F) injury and violence;

17 “(G) risky sexual behavior;

18 “(H) mental health problems;

19 “(I) dental and oral health problems; and

20 “(J) understanding informed consent;

21 “(4) to educate and guide regarding effective  
22 strategies to promote positive health behaviors with-  
23 in the family;

24 “(5) to promote community wellness and aware-  
25 ness; and



1           “(6) to educate and refer target populations to  
2           appropriate health care agencies and community-  
3           based programs and organizations in order to in-  
4           crease access to quality health care services, includ-  
5           ing preventive health services.

6           “(c) APPLICATION.—

7           “(1) IN GENERAL.—Each eligible entity that  
8           desires to receive a grant under subsection (a) shall  
9           submit an application to the Secretary, at such time,  
10          in such manner, and accompanied by such additional  
11          information as the Secretary may require.

12          “(2) CONTENTS.—Each application submitted  
13          pursuant to paragraph (1) shall—

14               “(A) describe the activities for which as-  
15               sistance under this section is sought;

16               “(B) contain an assurance that with re-  
17               spect to each community health worker pro-  
18               gram receiving funds under the grant awarded,  
19               such program provides training and supervision  
20               to community health workers to enable such  
21               workers to provide authorized program services;

22               “(C) contain an assurance that the appli-  
23               cant will evaluate the effectiveness of commu-  
24               nity health worker programs receiving funds  
25               under the grant;

1           “(D) contain an assurance that each com-  
2           munity health worker program receiving funds  
3           under the grant will provide services in the cul-  
4           tural context most appropriate for the individ-  
5           uals served by the program;

6           “(E) contain a plan to document and dis-  
7           seminate project description and results to  
8           other States and organizations as identified by  
9           the Secretary; and

10          “(F) describe plans to enhance the capac-  
11          ity of individuals to utilize health services and  
12          health-related social services under Federal,  
13          State, and local programs by—

14               “(i) assisting individuals in estab-  
15               lishing eligibility under the programs and  
16               in receiving the services or other benefits  
17               of the programs; and

18               “(ii) providing other services as the  
19               Secretary determines to be appropriate,  
20               that may include transportation and trans-  
21               lation services.

22          “(d) PRIORITY.—In awarding grants under sub-  
23          section (a), the Secretary shall give priority to those appli-  
24          cants—

25               “(1) who propose to target geographic areas—

1           “(A) with a high percentage of residents  
2           who are eligible for health insurance but are  
3           uninsured or underinsured; and

4           “(B) with a high percentage of families for  
5           whom English is not their primary language.

6           “(2) with experience in providing health or  
7           health-related social services to individuals who are  
8           underserved with respect to such services; and

9           “(3) with documented community activity and  
10          experience with community health workers.

11          “(e) COLLABORATION WITH ACADEMIC INSTITU-  
12          TIONS.—The Secretary shall encourage community health  
13          worker programs receiving funds under this section to col-  
14          laborate with academic institutions, including minority-  
15          serving institutions. Nothing in this section shall be con-  
16          strued to require such collaboration.

17          “(f) QUALITY ASSURANCE AND COST-EFFECTIVE-  
18          NESS.—The Secretary shall establish guidelines for assur-  
19          ing the quality of the training and supervision of commu-  
20          nity health workers under the programs funded under this  
21          section and for assuring the cost-effectiveness of such pro-  
22          grams.

23          “(g) MONITORING.—The Secretary shall monitor  
24          community health worker programs identified in approved  
25          applications and shall determine whether such programs

1 are in compliance with the guidelines established under  
2 subsection (f).

3 “(h) TECHNICAL ASSISTANCE.—The Secretary may  
4 provide technical assistance to community health worker  
5 programs identified in approved applications with respect  
6 to planning, developing, and operating programs under the  
7 grant.

8 “(i) REPORT TO CONGRESS.—

9 “(1) IN GENERAL.—Not later than 4 years  
10 after the date on which the Secretary first awards  
11 grants under subsection (a), the Secretary shall sub-  
12 mit to Congress a report regarding the grant  
13 project.

14 “(2) CONTENTS.—The report required under  
15 paragraph (1) shall include the following:

16 “(A) A description of the programs for  
17 which grant funds were used.

18 “(B) The number of individuals served.

19 “(C) An evaluation of—

20 “(i) the effectiveness of these pro-  
21 grams;

22 “(ii) the cost of these programs; and

23 “(iii) the impact of the project on the  
24 health outcomes of the community resi-  
25 dents.

1           “(D) Recommendations for sustaining the  
2           community health worker programs developed  
3           or assisted under this section.

4           “(E) Recommendations regarding training  
5           to enhance career opportunities for community  
6           health workers.

7           “(j) DEFINITIONS.—In this section:

8           “(1) COMMUNITY HEALTH WORKER.—The term  
9           ‘community health worker’ means an individual who  
10          promotes health or nutrition within the community  
11          in which the individual resides—

12               “(A) by serving as a liaison between com-  
13               munities and health care agencies;

14               “(B) by providing guidance and social as-  
15               sistance to community residents;

16               “(C) by enhancing community residents’  
17               ability to effectively communicate with health  
18               care providers;

19               “(D) by providing culturally and linguis-  
20               tically appropriate health or nutrition edu-  
21               cation;

22               “(E) by advocating for individual and com-  
23               munity health, including dental, oral, mental,  
24               and environmental health, or nutrition needs;  
25               and

1           “(F) by providing referral and followup  
2           services.

3           “(2) COMMUNITY SETTING.—The term ‘commu-  
4           nity setting’ means a home or a community organi-  
5           zation located in the neighborhood in which a partic-  
6           ipant resides.

7           “(3) ELIGIBLE ENTITY.—The term ‘eligible en-  
8           tity’ means—

9           “(A) a unit of State, territorial, local, or  
10          tribal government (including a federally recog-  
11          nized tribe or Alaska native villages); or

12          “(B) a community-based organization.

13          “(4) MEDICALLY UNDERSERVED COMMUNITY.—  
14          The term ‘medically underserved community’ means  
15          a community—

16          “(A) that has a substantial number of in-  
17          dividuals who are members of a medically un-  
18          derserved population, as defined by section  
19          330(b)(3); and

20          “(B) a significant portion of which is a  
21          health professional shortage area as designated  
22          under section 332.

23          “(5) SUPPORT.—The term ‘support’ means the  
24          provision of training, supervision, and materials  
25          needed to effectively deliver the services described in

1 subsection (b), reimbursement for services, and  
2 other benefits.

3 “(6) TARGET POPULATION.—The term ‘target  
4 population’ means women of reproductive age, re-  
5 gardless of their current childbearing status and  
6 children under 21 years of age.

7 “(k) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated to carry out this section  
9 \$15,000,000 for each of fiscal years 2010, 2011, 2012,  
10 2013, and 2014.”.

11 **SEC. 518. EXCEPTION FOR CITIZENS OF FREELY ASSOCI-**  
12 **ATED STATES.**

13 (a) IN GENERAL.—Section 402(a)(2) of the Personal  
14 Responsibility and Work Opportunity Reconciliation Act  
15 of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at  
16 the end the following:

17 “(N) EXCEPTION FOR CITIZENS OF FREE-  
18 LY ASSOCIATED STATES.—With respect to eligi-  
19 bility for benefits for the specified Federal pro-  
20 grams described in paragraph (3), paragraph  
21 (1) shall not apply to any individual who law-  
22 fully resides in the United States (including ter-  
23 ritories and possessions of the United States) in  
24 accordance with—

1 “(i) section 141 of the Compact of  
2 Free Association between the Government  
3 of the United States and the Government  
4 of the Federated States of Micronesia, ap-  
5 proved by Congress in the Compact of  
6 Free Association Amendments Act of  
7 2003;

8 “(ii) section 141 of the Compact of  
9 Free Association between the Government  
10 of the United States and the Government  
11 of the Republic of the Marshall Islands,  
12 approved by Congress in the Compact of  
13 Free Association Amendments Act of  
14 2003; or

15 “(iii) section 141 of the Compact of  
16 Free Association between the Government  
17 of the United States and the Government  
18 of Palau, approved by Congress in Public  
19 Law 99–658 (100 Stat. 3672).”.

20 (b) MEDICAID EXCEPTION.—Section 402(b)(2) of the  
21 Personal Responsibility and Work Opportunity Reconcili-  
22 ation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by  
23 adding at the end the following:

24 “(G) MEDICAID EXCEPTIONS FOR CITI-  
25 ZENS OF FREELY ASSOCIATED STATES.—With



1           respect to eligibility for benefits for the pro-  
2           grams defined in subparagraphs (A) and (C) of  
3           paragraph (3) (relating to Medicaid), paragraph  
4           (1) shall not apply to any individual who law-  
5           fully resides in the United States (including ter-  
6           ritories and possessions of the United States) in  
7           accordance with a Compact of Free Association  
8           referred to in subsection (a)(2)(N).”.

9           (c) QUALIFIED ALIEN.—Section 431(b) of the Per-  
10          sonal Responsibility and Work Opportunity Reconciliation  
11          Act of 1996 (8 U.S.C. 1641(b)) is amended—

12                 (1) in paragraph (6), by striking “or” at the  
13          end;

14                 (2) in paragraph (7), by striking the period at  
15          the end and inserting “; or”; and

16                 (3) by adding at the end the following:

17                         “(8) an individual who lawfully resides in the  
18          United States (including territories and possessions  
19          of the United States) in accordance with a Compact  
20          of Free Association referred to in section  
21          402(a)(2)(N).”.

22           (d) INCREASED FMAP.—The third sentence of sec-  
23          tion 1905(b) of the Social Security Act (42 U.S.C.  
24          1396d(b)) is amended by inserting before the period at  
25          the end the following: “and for services furnished to indi-

1 viduals described in section 431(b)(8) of the Personal Re-  
2 sponsibility and Work Opportunity Reconciliation Act of  
3 1996”.

4 **SEC. 519. MEDICARE GRADUATE MEDICAL EDUCATION.**

5 (a) CLARIFICATION OF CONGRESSIONAL INTENT RE-  
6 GARDING THE COUNTING OF RESIDENTS IN A NONHOS-  
7 PITAL SETTING.—

8 (1) D–GME.—Section 1886(h)(4)(E) of the So-  
9 cial Security Act (42 U.S.C. 1395ww(h)(4)(E)) is  
10 amended by adding at the end the following new  
11 sentences: “For purposes of the preceding sentence,  
12 the term ‘all, or substantially all, of the costs for the  
13 training program’ means the stipends and benefits  
14 provided to the resident and other amounts, if any,  
15 as determined by the hospital and the entity oper-  
16 ating the nonhospital setting. The hospital is not re-  
17 quired to pay the entity any amounts other than  
18 those determined by the hospital and the entity in  
19 order for the hospital to be considered to have in-  
20 curred all, or substantially all, of the costs for the  
21 training program in that setting.”.

22 (2) IME.—Section 1886(d)(5)(B)(iv) of the So-  
23 cial Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is  
24 amended by adding at the end the following new  
25 sentences: “For purposes of the preceding sentence,

1 the term ‘all, or substantially all, of the costs for the  
2 training program’ means the stipends and benefits  
3 provided to the resident and other amounts, if any,  
4 as determined by the hospital and the entity oper-  
5 ating the nonhospital setting. The hospital is not re-  
6 quired to pay the entity any amounts other than  
7 those determined by the hospital and the entity in  
8 order for the hospital to be considered to have in-  
9 curred all, or substantially all, of the costs for the  
10 training program in that setting.”.

11 (3) EFFECTIVE DATE.—The amendments made  
12 by this subsection shall take effect on January 1,  
13 2010.

14 (b) CLARIFICATION OF ELIGIBILITY OF A NONRURAL  
15 HOSPITAL THAT HAS A TRAINING PROGRAM WITH AN  
16 INTEGRATED RURAL TRACK.—

17 (1) IN GENERAL.—Section 1886(h)(4)(H) of  
18 the Social Security Act (42 U.S.C.  
19 1395ww(h)(4)(H)) is amended—

20 (A) in clause (iv), by inserting “(as defined  
21 in clause (vi))” after “an integrated rural  
22 track”; and

23 (B) by adding at the end the following new  
24 clause:

1                   “(vi) DEFINITION OF ACCREDITED  
2                   TRAINING PROGRAM WITH AN INTEGRATED  
3                   RURAL TRACK.—For purposes of clause  
4                   (iv), the term ‘accredited training program  
5                   with an integrated rural track’ means an  
6                   accredited medical residency training pro-  
7                   gram located in an urban area which offers  
8                   a curriculum for all residents in the pro-  
9                   gram that includes the following character-  
10                  istics:

11                         “(I) A minimum of 3 block  
12                         months of rural rotations. During  
13                         such 3 block months, the resident is  
14                         in a rural area for 4 weeks or a  
15                         month.

16                         “(II) A stated mission for train-  
17                         ing rural physicians.

18                         “(III) A minimum of 3 months of  
19                         obstetrical training, or an equivalent  
20                         longitudinal experience.

21                         “(IV) A minimum of 4 months of  
22                         pediatric training that includes neo-  
23                         natal, ambulatory, inpatient, and  
24                         emergency experiences through rota-

tions, or an equivalent longitudinal experience.

“(V) A minimum of 2 months of emergency medicine rotations, or an equivalent longitudinal experience.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection apply with respect to—

(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after January 1, 2010; and

(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after January 1, 2010.

**SEC. 520. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MINORITY COMMUNITIES.**

(a) EXPANDED FUNDING.—The Secretary, in collaboration with the Director of the Office of Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Services Administration, shall provide funds and carry out activities to expand the Minority HIV/AIDS Initiative.

1       (b) USE OF FUNDS.—The additional funds made  
2 available under this section may be used, through the Mi-  
3 nority AIDS Initiative, to support the following activities:

4           (1) Providing technical assistance and infra-  
5 structure support to reduce HIV/AIDS in minority  
6 populations.

7           (2) Increasing minority populations' access to  
8 HIV/AIDS prevention and care services.

9           (3) Building strong community programs and  
10 partnerships to address HIV prevention and the  
11 health care needs of specific racial and ethnic minor-  
12 ity populations.

13       (c) PRIORITY INTERVENTIONS.—Within the racial  
14 and ethnic minority populations referred to in subsection  
15 (b), priority in conducting intervention services shall be  
16 given to—

17           (1) women;

18           (2) youth;

19           (3) men who engage in homosexual activity;

20           (4) persons who engage in intravenous drug  
21 abuse;

22           (5) homeless individuals; and

23           (6) individuals incarcerated or in the penal sys-  
24 tem.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-  
2 rying out this section, there are authorized to be appro-  
3 priated \$610,000,000 for fiscal year 2010 and such sums  
4 as may be necessary for each of fiscal years 2011 through  
5 2014.

6 **SEC. 521. GRANTS FOR RACIAL AND ETHNIC APPROACHES**  
7 **TO COMMUNITY HEALTH.**

8 (a) PURPOSE.—It is the purpose of this section to  
9 provide for the awarding of grants to assist communities  
10 in mobilizing and organizing resources in support of effec-  
11 tive and sustainable programs that will reduce or eliminate  
12 disparities in health and healthcare experienced by racial  
13 and ethnic minority individuals.

14 (b) AUTHORITY TO AWARD GRANTS.—The Sec-  
15 retary, acting through the Centers for Disease Control and  
16 Prevention, shall award grants to eligible entities to assist  
17 in designing, implementing, and evaluating culturally and  
18 linguistically appropriate, science-based and community-  
19 driven sustainable strategies to eliminate racial and ethnic  
20 health and healthcare disparities.

21 (c) ELIGIBLE ENTITIES.—To be eligible to receive a  
22 grant under this section, an entity shall—

23 (1) represent a coalition—

24 (A) whose principal purpose is to develop  
25 and implement interventions to reduce or elimi-

1           nate a health or healthcare disparity in a tar-  
2           geted racial or ethnic minority group in the  
3           community served by the coalition; and

4           (B) that includes—

5           (i) members selected from among—

6           (I) public health departments;

7           (II) community-based organiza-  
8           tions;

9           (III) university and research or-  
10          ganizations;

11          (IV) American Indian tribal or-  
12          ganizations, national American Indian  
13          organizations, Indian Health Service,  
14          or organizations serving Alaska Na-  
15          tives; and

16          (V) interested public or private  
17          healthcare providers or organizations  
18          as deemed appropriate by the Sec-  
19          retary; and

20          (ii) at least 1 member from a commu-  
21          nity-based organization that represents the  
22          targeted racial or ethnic minority group;  
23          and

24          (2) submit to the Secretary an application at  
25          such time, in such manner, and containing such in-



1       formation as the Secretary may require, which shall  
2       include—

3               (A) a description of the targeted racial or  
4       ethnic populations in the community to be  
5       served under the grant;

6               (B) a description of at least 1 health dis-  
7       parity that exists in the racial or ethnic tar-  
8       geted populations, including health issues such  
9       as infant mortality, breast and cervical cancer  
10      screening and management, cardiovascular dis-  
11      ease, diabetes, child and adult immunization  
12      levels, or other health priority area(s) as des-  
13      ignated by the Secretary; and

14              (C) a demonstration of a proven record of  
15      accomplishment of the coalition members in  
16      serving and working with the targeted commu-  
17      nity.

18      (d) SUSTAINABILITY.—The Secretary shall give pri-  
19      ority to an eligible entity under this section if the entity  
20      agrees that, with respect to the costs to be incurred by  
21      the entity in carrying out the activities for which the grant  
22      was awarded, the entity (and each of the participating  
23      partners in the coalition represented by the entity) will  
24      maintain its expenditures of non-Federal funds for such  
25      activities at a level that is not less than the level of such

1 expenditures during the fiscal year immediately preceding  
2 the first fiscal year for which the grant is awarded.

3 (e) NONDUPLICATION.—Funds provided through this  
4 grant program should supplement, not supplant, existing  
5 Federal funding, and the funds should not be used to du-  
6 plicate the activities of the other health disparity grant  
7 programs in this Act.

8 (f) TECHNICAL ASSISTANCE.—The Secretary may,  
9 either directly or by grant or contract, provide any entity  
10 that receives a grant under this section with technical and  
11 other nonfinancial assistance necessary to meet the re-  
12 quirements of this section.

13 (g) DISSEMINATION.—The Secretary shall encourage  
14 and enable grantees to share best practices, evaluation re-  
15 sults, and reports with communities not affiliated with  
16 grantees using the Internet, conferences, and other perti-  
17 nent information regarding the projects funded by this  
18 section, including the outreach efforts of the Office of Mi-  
19 nority Health and Health Disparity Elimination and the  
20 Centers for Disease Control and Prevention.

21 (h) ADMINISTRATIVE BURDENS.—The Secretary  
22 shall make every effort to minimize duplicative or unneces-  
23 sary administrative burdens on grantees.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
 2 are authorized to be appropriated such sums as may be  
 3 necessary to carry out the Public Health Service Act.

4 **SEC. 522. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

5 (a) ELIMINATION OF ISOLATION TEST FOR COST-  
 6 BASED AMBULANCE REIMBURSEMENT.—

7 (1) IN GENERAL.—Section 1834(l)(8) of the  
 8 Social Security Act (42 U.S.C. 1395m(l)(8)) is  
 9 amended—

10 (A) in subparagraph (B)—

11 (i) by striking “owned and”; and

12 (ii) by inserting “(including when  
 13 such services are provided by the entity  
 14 under an arrangement with the hospital)”  
 15 after “hospital”; and

16 (B) by striking the comma at the end of  
 17 subparagraph (B) and all that follows and in-  
 18 serting a period.

19 (2) EFFECTIVE DATE.—The amendments made  
 20 by this subsection shall apply to services furnished  
 21 on or after January 1, 2010.

22 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE  
 23 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT  
 24 REQUIREMENT.—

1           (1) IN GENERAL.—Section 1820(c)(2) of the  
2       Social Security Act (42 U.S.C. 1395i–4(c)(2)) is  
3       amended—

4           (A) in subparagraph (B)(iii), by striking  
5       “provides not more than” and inserting “sub-  
6       ject to subparagraph (F), provides not more  
7       than”; and

8           (B) by adding at the end the following new  
9       subparagraph:

10          “(F) ALTERNATIVE TO 25 INPATIENT BED  
11       LIMIT REQUIREMENT.—

12           “(i) IN GENERAL.—A State may elect  
13       to treat a facility, with respect to the des-  
14       ignation of the facility for a cost reporting  
15       period, as satisfying the requirement of  
16       subparagraph (B)(iii) relating to a max-  
17       imum number of acute care inpatient beds  
18       if the facility elects, in accordance with a  
19       method specified by the Secretary and be-  
20       fore the beginning of the cost reporting pe-  
21       riod, to meet the requirement under clause  
22       (ii).

23           “(ii) ALTERNATE REQUIREMENT.—  
24       The requirement under this clause, with  
25       respect to a facility and a cost reporting

1 period, is that the total number of inpa-  
2 tient bed days described in subparagraph  
3 (B)(iii) during such period will not exceed  
4 7,300. For purposes of this subparagraph,  
5 an individual who is an inpatient in a bed  
6 in the facility for a single day shall be  
7 counted as one inpatient bed day.

8 “(iii) WITHDRAWAL OF ELECTION.—  
9 The option described in clause (i) shall not  
10 apply to a facility for a cost reporting pe-  
11 riod if the facility (for any two consecutive  
12 cost reporting periods during the previous  
13 5 cost reporting periods) was treated under  
14 such option and had a total number of in-  
15 patient bed days for each of such two cost  
16 reporting periods that exceeded the num-  
17 ber specified in such clause.”.

18 (2) EFFECTIVE DATE.—The amendments made  
19 by paragraph (1) shall apply to cost reporting peri-  
20 ods beginning on or after the date of the enactment  
21 of this Act.

1 **SEC. 523. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
2 **PIST SERVICES AND MENTAL HEALTH COUN-**  
3 **SELOR SERVICES UNDER PART B OF THE**  
4 **MEDICARE PROGRAM.**

5 (a) COVERAGE OF SERVICES.—

6 (1) IN GENERAL.—Section 1861(s)(2) of the  
7 Social Security Act (42 U.S.C. 1395x(s)(2)) is  
8 amended—

9 (A) in subparagraph (DD), by striking  
10 “and” at the end;

11 (B) in subparagraph (EE), by inserting  
12 “and” at the end; and

13 (C) by adding at the end the following new  
14 subparagraph:

15 “(FF) marriage and family therapist services  
16 (as defined in subsection (ccc)(1)) and mental health  
17 counselor services (as defined in subsection  
18 (hhh)(3));”.

19 (2) DEFINITIONS.—Section 1861 of such Act  
20 (42 U.S.C. 1395x) is amended by adding at the end  
21 the following new subsection:

22 “Marriage and Family Therapist Services; Marriage and  
23 Family Therapist; Mental Health Counselor Serv-  
24 ices; Mental Health Counselor

25 “(hhh)(1) The term ‘marriage and family therapist  
26 services’ means services performed by a marriage and

1 family therapist (as defined in paragraph (2)) for the diag-  
2 nosis and treatment of mental illnesses, which the mar-  
3 riage and family therapist is legally authorized to perform  
4 under State law (or the State regulatory mechanism pro-  
5 vided by State law) of the State in which such services  
6 are performed, as would otherwise be covered if furnished  
7 by a physician or as an incident to a physician's profes-  
8 sional service, but only if no facility or other provider  
9 charges or is paid any amounts with respect to the fur-  
10 nishing of such services.

11       “(2) The term ‘marriage and family therapist’ means  
12 an individual who—

13               “(A) possesses a master's or doctoral degree  
14 which qualifies for licensure or certification as a  
15 marriage and family therapist pursuant to State  
16 law;

17               “(B) after obtaining such degree has performed  
18 at least 2 years of clinical supervised experience in  
19 marriage and family therapy; and

20               “(C) in the case of an individual performing  
21 services in a State that provides for licensure or cer-  
22 tification of marriage and family therapists, is li-  
23 censed or certified as a marriage and family thera-  
24 pist in such State.

1       “(3) The term ‘mental health counselor services’  
2 means services performed by a mental health counselor (as  
3 defined in paragraph (4)) for the diagnosis and treatment  
4 of mental illnesses which the mental health counselor is  
5 legally authorized to perform under State law (or the  
6 State regulatory mechanism provided by the State law) of  
7 the State in which such services are performed, as would  
8 otherwise be covered if furnished by a physician or as inci-  
9 dent to a physician’s professional service, but only if no  
10 facility or other provider charges or is paid any amounts  
11 with respect to the furnishing of such services.

12       “(4) The term ‘mental health counselor’ means an  
13 individual who—

14               “(A) possesses a master’s or doctor’s degree in  
15 mental health counseling or a related field;

16               “(B) after obtaining such a degree has per-  
17 formed at least 2 years of supervised mental health  
18 counselor practice; and

19               “(C) in the case of an individual performing  
20 services in a State that provides for licensure or cer-  
21 tification of mental health counselors or professional  
22 counselors, is licensed or certified as a mental health  
23 counselor or professional counselor in such State.”.

24               (3) PROVISION FOR PAYMENT UNDER PART  
25 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.



1       1395k(a)(2)(B)) is amended by adding at the end  
2       the following new clause:

3                   “(v) marriage and family therapist  
4                   services and mental health counselor serv-  
5                   ices;”.

6           (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)  
7       of such Act (42 U.S.C. 1395l(a)(1)) is amended—

8                   (A) by striking “and (W)” and inserting  
9                   “(W)”; and

10                  (B) by inserting before the semicolon at  
11                  the end the following: “, and (X) with respect  
12                  to marriage and family therapist services and  
13                  mental health counselor services under section  
14                  1861(s)(2)(FF), the amounts paid shall be 80  
15                  percent of the lesser of the actual charge for  
16                  the services or 75 percent of the amount deter-  
17                  mined for payment of a psychologist under sub-  
18                  paragraph (L)”.

19           (5) EXCLUSION OF MARRIAGE AND FAMILY  
20       THERAPIST SERVICES AND MENTAL HEALTH COUN-  
21       SELOR SERVICES FROM SKILLED NURSING FACILITY  
22       PROSPECTIVE PAYMENT SYSTEM.—Section  
23       1888(e)(2)(A)(ii) of such Act (42 U.S.C.  
24       1395yy(e)(2)(A)(ii)) is amended by inserting “mar-  
25       riage and family therapist services (as defined in

1 section 1861(hhh)(1)), mental health counselor serv-  
2 ices (as defined in section 1861(hhh)(3)),” after  
3 “qualified psychologist services,”.

4 (6) INCLUSION OF MARRIAGE AND FAMILY  
5 THERAPISTS AND MENTAL HEALTH COUNSELORS AS  
6 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-  
7 tion 1842(b)(18)(C) of such Act (42 U.S.C.  
8 1395u(b)(18)(C)) is amended by adding at the end  
9 the following new clauses:

10 “(vii) A marriage and family therapist (as de-  
11 fined in section 1861(hhh)(2)).

12 “(viii) A mental health counselor (as defined in  
13 section 1861(hhh)(4)).”.

14 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-  
15 ICES PROVIDED IN CERTAIN SETTINGS.—

16 (1) RURAL HEALTH CLINICS AND FEDERALLY  
17 QUALIFIED HEALTH CENTERS.—Section  
18 1861(aa)(1)(B) of the Social Security Act (42  
19 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or  
20 by a clinical social worker (as defined in subsection  
21 (hh)(1)),” and inserting “, by a clinical social worker  
22 (as defined in subsection (hh)(1)), by a marriage  
23 and family therapist (as defined in subsection  
24 (hhh)(2)), or by a mental health counselor (as de-  
25 fined in subsection (hhh)(4)),”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2010.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 523, is amended by adding at the end of the following new subsection:

23 “(iii)(1) The term ‘rural community hospital’ means  
24 a hospital (as defined in subsection (e)) that—

1           “(A) is located in a rural area (as defined in  
2           section 1886(d)(2)(D)) or treated as being so lo-  
3           cated pursuant to section 1886(d)(8)(E);

4           “(B) subject to paragraph (2), has less than 51  
5           acute care inpatient beds, as reported in its most re-  
6           cent cost report;

7           “(C) makes available 24-hour emergency care  
8           services;

9           “(D) subject to paragraph (3), has a provider  
10          agreement in effect with the Secretary and is open  
11          to the public as of January 1, 2010; and

12          “(E) applies to the Secretary for such designa-  
13          tion.

14          “(2) For purposes of paragraph (1)(B), beds in a  
15          psychiatric or rehabilitation unit of the hospital which is  
16          a distinct part of the hospital shall not be counted.

17          “(3) Subparagraph (1)(D) shall not be construed to  
18          prohibit any of the following from qualifying as a rural  
19          community hospital:

20                 “(A) A replacement facility (as defined by the  
21                 Secretary in regulations in effect on January 1,  
22                 2010) with the same service area (as defined by the  
23                 Secretary in regulations in effect on such date).

24                 “(B) A facility obtaining a new provider num-  
25                 ber pursuant to a change of ownership.

1           “(C) A facility which has a binding written  
2           agreement with an outside, unrelated party for the  
3           construction, reconstruction, lease, rental, or financ-  
4           ing of a building as of January 1, 2010.

5           “(4) Nothing in this subsection shall be construed as  
6           prohibiting a critical access hospital from qualifying as a  
7           rural community hospital if the critical access hospital  
8           meets the conditions otherwise applicable to hospitals  
9           under subsection (e) and section 1866.

10          “(5) Nothing in this subsection shall be construed as  
11          prohibiting a rural community hospital participating in  
12          the demonstration program under Section 410A of the  
13          Medicare Prescription Drug, Improvement, and Mod-  
14          ernization Act of 2003 (Public Law 108–173; 117 Stat.  
15          2313) from qualifying as a rural community hospital if  
16          the rural community hospital meets the conditions other-  
17          wise applicable to hospitals under subsection (e) and sec-  
18          tion 1866.”.

19          (b) PAYMENT.—

20                 (1) INPATIENT HOSPITAL SERVICES.—Section  
21          1814 of the Social Security Act (42 U.S.C. 1395f)  
22          is amended by adding at the end the following new  
23          subsection:

1     “Payment for Inpatient Services Furnished in Rural  
2                                   Community Hospitals

3           “(m) The amount of payment under this part for in-  
4 patient hospital services furnished in a rural community  
5 hospital, other than such services furnished in a psy-  
6 chiatric or rehabilitation unit of the hospital which is a  
7 distinct part, is, at the election of the hospital in the appli-  
8 cation referred to in section 1861(iii)(1)(E)—

9                   “(1) 101 percent of the reasonable costs of pro-  
10 viding such services, without regard to the amount  
11 of the customary or other charge, or

12                   “(2) the amount of payment provided for under  
13 the prospective payment system for inpatient hos-  
14 pital services under section 1886(d).”.

15           (2) OUTPATIENT SERVICES.—Section 1834 of  
16 such Act (42 U.S.C. 1395m) is amended by adding  
17 at the end the following new subsection:

18           “(n) PAYMENT FOR OUTPATIENT SERVICES FUR-  
19 NISHED IN RURAL COMMUNITY HOSPITALS.—The  
20 amount of payment under this part for outpatient services  
21 furnished in a rural community hospital is, at the election  
22 of the hospital in the application referred to in section  
23 1861(iii)(1)(E)—

24                   “(1) 101 percent of the reasonable costs of pro-  
25 viding such services, without regard to the amount

1 of the customary or other charge and any limitation  
 2 under section 1861(v)(1)(U), or

3 “(2) the amount of payment provided for under  
 4 the prospective payment system for covered OPD  
 5 services under section 1833(t).”.

6 (3) EXEMPTION FROM 30-PERCENT REDUCTION  
 7 IN REIMBURSEMENT FOR BAD DEBT.—Section  
 8 1861(v)(1)(T) of such Act (42 U.S.C.  
 9 1395x(v)(1)(T)) is amended by inserting “(other  
 10 than for a rural community hospital)” after “In de-  
 11 termining such reasonable costs for hospitals”.

12 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT  
 13 SERVICES.—Section 1834(n) of such Act (as added by  
 14 subsection (b)(2)) is amended—

15 (1) by redesignating paragraphs (1) and (2) as  
 16 subparagraphs (A) and (B), respectively;

17 (2) by inserting “(1)” after “(n)”; and

18 (3) by adding at the end the following:

19 “(2) The amounts of beneficiary cost-sharing for out-  
 20 patient services furnished in a rural community hospital  
 21 under this part shall be as follows:

22 “(A) For items and services that would have  
 23 been paid under section 1833(t) if provided by a  
 24 hospital, the amount of cost-sharing determined  
 25 under paragraph (8) of such section.

1           “(B) For items and services that would have  
2       been paid under section 1833(h) if furnished by a  
3       provider or supplier, no cost-sharing shall apply.

4           “(C) For all other items and services, the  
5       amount of cost-sharing that would apply to the item  
6       or service under the methodology that would be used  
7       to determine payment for such item or service if pro-  
8       vided by a physician, provider, or supplier, as the  
9       case may be.”.

10       (d) CONFORMING AMENDMENTS.—

11           (1) PART A PAYMENT.—Section 1814(b) of  
12       such Act (42 U.S.C. 1395f(b)) is amended in the  
13       matter preceding paragraph (1) by inserting “other  
14       than inpatient hospital services furnished by a rural  
15       community hospital,” after “critical access hospital  
16       services,”.

17           (2) PART B PAYMENT.—Section 1833(a) of  
18       such Act (42 U.S.C. 1395l(a)) is amended—

19           (A) in paragraph (2), in the matter before  
20       subparagraph (A), by striking “and (I)” and in-  
21       serting “(I), and (K)”;

22           (B) by striking “and” at the end of para-  
23       graph (8);

24           (C) by striking the period at the end of  
25       paragraph (9) and inserting “; and”; and



1 (D) by adding at the end the following:

2 “(10) in the case of outpatient services fur-  
3 nished by a rural community hospital, the amounts  
4 described in section 1834(n).”.

5 (3) TECHNICAL AMENDMENTS.—

6 (A) CONSULTATION WITH STATE AGEN-  
7 CIES.—Section 1863 of such Act (42 U.S.C.  
8 1395z) is amended by striking “and (dd)(2)”  
9 and inserting “(dd)(2), (mm)(1), and (iii)(1)”.

10 (B) PROVIDER AGREEMENTS.—Section  
11 1866(a)(2)(A) of such Act (42 U.S.C.  
12 1395cc(a)(2)(A)) is amended by inserting “sec-  
13 tion 1834(n)(2),” after “section 1833(b),”.

14 (e) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to items and services furnished on  
16 or after October 1, 2009.

17 **SEC. 525. MEDICARE REMOTE MONITORING PILOT**  
18 **PROJECTS.**

19 (a) PILOT PROJECTS.—

20 (1) IN GENERAL.—Not later than 9 months  
21 after the date of enactment of this Act, the Sec-  
22 retary of Health and Human Services (in this sec-  
23 tion referred to as the “Secretary”) shall conduct  
24 pilot projects under title XVIII of the Social Secu-  
25 rity Act for the purpose of providing incentives to

1 home health agencies to utilize home monitoring and  
2 communications technologies that—

3 (A) enhance health outcomes for Medicare  
4 beneficiaries; and

5 (B) reduce expenditures under such title.

6 (2) SITE REQUIREMENTS.—

7 (A) URBAN AND RURAL.—The Secretary  
8 shall conduct the pilot projects under this sec-  
9 tion in both urban and rural areas.

10 (B) SITE IN A SMALL STATE.—The Sec-  
11 retary shall conduct at least 3 of the pilot  
12 projects in a State with a population of less  
13 than 1,000,000.

14 (3) DEFINITION OF HOME HEALTH AGENCY.—

15 In this section, the term “home health agency” has  
16 the meaning given that term in section 1861(o) of  
17 the Social Security Act (42 U.S.C. 1395x(o)).

18 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE  
19 OF PROJECTS.—The Secretary shall specify the criteria  
20 for identifying those Medicare beneficiaries who shall be  
21 considered within the scope of the pilot projects under this  
22 section for purposes of the application of subsection (c)  
23 and for the assessment of the effectiveness of the home  
24 health agency in achieving the objectives of this section.  
25 Such criteria may provide for the inclusion in the projects

1 of Medicare beneficiaries who begin receiving home health  
2 services under title XVIII of the Social Security Act after  
3 the date of the implementation of the projects.

4 (c) INCENTIVES.—

5 (1) PERFORMANCE TARGETS.—The Secretary  
6 shall establish for each home health agency partici-  
7 pating in a pilot project under this section a per-  
8 formance target using one of the following meth-  
9 odologies, as determined appropriate by the Sec-  
10 retary:

11 (A) ADJUSTED HISTORICAL PERFORMANCE  
12 TARGET.—The Secretary shall establish for the  
13 agency—

14 (i) a base expenditure amount equal  
15 to the average total payments made to the  
16 agency under parts A and B of title XVIII  
17 of the Social Security Act for Medicare  
18 beneficiaries determined to be within the  
19 scope of the pilot project in a base period  
20 determined by the Secretary; and

21 (ii) an annual per capita expenditure  
22 target for such beneficiaries, reflecting the  
23 base expenditure amount adjusted for risk  
24 and adjusted growth rates.

1 (B) COMPARATIVE PERFORMANCE TAR-  
2 GET.—The Secretary shall establish for the  
3 agency a comparative performance target equal  
4 to the average total payments under such parts  
5 A and B during the pilot project for comparable  
6 individuals in the same geographic area that  
7 are not determined to be within the scope of the  
8 pilot project.

9 (2) INCENTIVE.—Subject to paragraph (3), the  
10 Secretary shall pay to each participating home care  
11 agency an incentive payment for each year under the  
12 pilot project equal to a portion of the Medicare sav-  
13 ings realized for such year relative to the perform-  
14 ance target under paragraph (1).

15 (3) LIMITATION ON EXPENDITURES.—The Sec-  
16 retary shall limit incentive payments under this sec-  
17 tion in order to ensure that the aggregate expendi-  
18 tures under title XVIII of the Social Security Act  
19 (including incentive payments under this subsection)  
20 do not exceed the amount that the Secretary esti-  
21 mates would have been expended if the pilot projects  
22 under this section had not been implemented.

23 (d) WAIVER AUTHORITY.—The Secretary may waive  
24 such provisions of titles XI and XVIII of the Social Secu-

1 rity Act as the Secretary determines to be appropriate for  
2 the conduct of the pilot projects under this section.

3 (e) REPORT TO CONGRESS.—Not later than 5 years  
4 after the date that the first pilot project under this section  
5 is implemented, the Secretary shall submit to Congress a  
6 report on the pilot projects. Such report shall contain a  
7 detailed description of issues related to the expansion of  
8 the projects under subsection (f) and recommendations for  
9 such legislation and administrative actions as the Sec-  
10 retary considers appropriate.

11 (f) EXPANSION.—If the Secretary determines that  
12 any of the pilot projects under this section enhance health  
13 outcomes for Medicare beneficiaries and reduce expendi-  
14 tures under title XVIII of the Social Security Act, the Sec-  
15 retary may initiate comparable projects in additional  
16 areas.

17 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON  
18 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-  
19 tive payment under this section—

20 (1) shall be in addition to the payments that a  
21 home health agency would otherwise receive under  
22 title XVIII of the Social Security Act for the provi-  
23 sion of home health services; and

24 (2) shall have no effect on the amount of such  
25 payments.

1 **SEC. 526. RURAL HEALTH QUALITY ADVISORY COMMISSION**  
2 **AND DEMONSTRATION PROJECTS.**

3 (a) RURAL HEALTH QUALITY ADVISORY COMMISS-  
4 SION.—

5 (1) ESTABLISHMENT.—Not later than 6  
6 months after the date of the enactment of this sec-  
7 tion, the Secretary of Health and Human Services  
8 (in this section referred to as the “Secretary”) shall  
9 establish a commission to be known as the Rural  
10 Health Quality Advisory Commission (in this section  
11 referred to as the “Commission”).

12 (2) DUTIES OF COMMISSION.—

13 (A) NATIONAL PLAN.—The Commission  
14 shall develop, coordinate, and facilitate imple-  
15 mentation of a national plan for rural health  
16 quality improvement. The national plan shall—

17 (i) identify objectives for rural health  
18 quality improvement;

19 (ii) identify strategies to eliminate  
20 known gaps in rural health system capacity  
21 and improve rural health quality; and

22 (iii) provide for Federal programs to  
23 identify opportunities for strengthening  
24 and aligning policies and programs to im-  
25 prove rural health quality.

1                   (B) DEMONSTRATION PROJECTS.—The  
2                   Commission shall design demonstration projects  
3                   to test alternative models for rural health qual-  
4                   ity improvement, including with respect to both  
5                   personal and population health.

6                   (C) MONITORING.—The Commission shall  
7                   monitor progress toward the objectives identi-  
8                   fied pursuant to paragraph (1)(A).

9                   (3) MEMBERSHIP.—

10                  (A) NUMBER.—The Commission shall be  
11                  composed of 11 members appointed by the Sec-  
12                  retary.

13                  (B) SELECTION.—The Secretary shall se-  
14                  lect the members of the Commission from  
15                  among individuals with significant rural health  
16                  care and health care quality expertise, including  
17                  expertise in clinical health care, health care  
18                  quality research, population or public health, or  
19                  purchaser organizations.

20                  (4) CONTRACTING AUTHORITY.—Subject to the  
21                  availability of funds, the Commission may enter into  
22                  contracts and make other arrangements, as may be  
23                  necessary to carry out the duties described in para-  
24                  graph (2).

1           (5) STAFF.—Upon the request of the Commis-  
2           sion, the Secretary may detail, on a reimbursable  
3           basis, any of the personnel of the Office of Rural  
4           Health Policy of the Health Resources and Services  
5           Administration, the Agency for Health Care Quality  
6           and Research, or the Centers for Medicare & Med-  
7           icaid Services to the Commission to assist in car-  
8           rying out this subsection.

9           (6) REPORTS TO CONGRESS.—Not later than 1  
10          year after the establishment of the Commission, and  
11          annually thereafter, the Commission shall submit a  
12          report to the Congress on rural health quality. Each  
13          such report shall include the following:

14                (A) An inventory of relevant programs and  
15                recommendations for improved coordination and  
16                integration of policy and programs.

17                (B) An assessment of achievement of the  
18                objectives identified in the national plan devel-  
19                oped under paragraph (2) and recommenda-  
20                tions for realizing such objectives.

21                (C) Recommendations on Federal legisla-  
22                tion, regulations, or administrative policies to  
23                enhance rural health quality and outcomes.

24          (b) RURAL HEALTH QUALITY DEMONSTRATION  
25 PROJECTS.—



1           (1) IN GENERAL.—Not later than 270 days  
2       after the date of the enactment of this section, the  
3       Secretary, in consultation with the Rural Health  
4       Quality Advisory Commission, the Office of Rural  
5       Health Policy of the Health Resources and Services  
6       Administration, the Agency for Healthcare Research  
7       and Quality, and the Centers for Medicare & Med-  
8       icaid Services, shall make grants to eligible entities  
9       for 5 demonstration projects to implement and  
10      evaluate methods for improving the quality of health  
11      care in rural communities. Each such demonstration  
12      project shall include—

13           (A) alternative community models that—

14               (i) will achieve greater integration of  
15              personal and population health services;  
16              and

17               (ii) address safety, effectiveness,  
18              patient- or community-centeredness, timeli-  
19              ness, efficiency, and equity (the six aims  
20              identified by the Institute of Medicine of  
21              the National Academies in its report enti-  
22              tled “Crossing the Quality Chasm: A New  
23              Health System for the 21st Century” re-  
24              leased on March 1, 2001);

1 (B) innovative approaches to the financing  
2 and delivery of health services to achieve rural  
3 health quality goals; and

4 (C) development of quality improvement  
5 support structures to assist rural health sys-  
6 tems and professionals (such as workforce sup-  
7 port structures, quality monitoring and report-  
8 ing, clinical care protocols, and information  
9 technology applications).

10 (2) ELIGIBLE ENTITIES.—In this subsection,  
11 the term “eligible entity” means a consortium  
12 that—

13 (A) shall include—

14 (i) at least one health care provider or  
15 health care delivery system located in a  
16 rural area; and

17 (ii) at least one organization rep-  
18 resenting multiple community stakeholders;  
19 and

20 (B) may include other partners such as  
21 rural research centers.

22 (3) CONSULTATION.—In developing the pro-  
23 gram for awarding grants under this subsection, the  
24 Secretary shall consult with the Administrator of the  
25 Agency for Healthcare Research and Quality, rural

1 health care providers, rural health care researchers,  
2 and private and non-profit groups (including na-  
3 tional associations) which are undertaking similar  
4 efforts.

5 (4) EXPEDITED WAIVERS.—The Secretary shall  
6 expedite the processing of any waiver that—

7 (A) is authorized under title XVIII or XIX  
8 of the Social Security Act (42 U.S.C. 1395 et  
9 seq.); and

10 (B) is necessary to carry out a demonstra-  
11 tion project under this subsection.

12 (5) DEMONSTRATION PROJECT SITES.—The  
13 Secretary shall ensure that the 5 demonstration  
14 projects funded under this subsection are conducted  
15 at a variety of sites representing the diversity of  
16 rural communities in the Nation.

17 (6) DURATION.—Each demonstration project  
18 under this subsection shall be for a period of 4  
19 years.

20 (7) INDEPENDENT EVALUATION.—The Sec-  
21 retary shall enter into an arrangement with an enti-  
22 ty that has experience working directly with rural  
23 health systems for the conduct of an independent  
24 evaluation of the program carried out under this  
25 subsection.

1           (8) REPORT.—Not later than one year after the  
2 conclusion of all of the demonstration projects fund-  
3 ed under this subsection, the Secretary shall submit  
4 a report to the Congress on the results of such  
5 projects. The report shall include—

6           (A) an evaluation of patient access to care,  
7 patient outcomes, and an analysis of the cost  
8 effectiveness of each such project; and

9           (B) recommendations on Federal legisla-  
10 tion, regulations, or administrative policies to  
11 enhance rural health quality and outcomes.

12       (c) APPROPRIATION.—

13           (1) IN GENERAL.—Out of funds in the Treas-  
14 ury not otherwise appropriated, there are appro-  
15 priated to the Secretary to carry out this section  
16 \$30,000,000 for the period of fiscal years 2010  
17 through 2014.

18           (2) AVAILABILITY.—

19           (A) IN GENERAL.—Funds appropriated  
20 under paragraph (1) shall remain available for  
21 expenditure through fiscal year 2014.

22           (B) REPORT.—For purposes of carrying  
23 out subsection (b)(8), funds appropriated under  
24 paragraph (1) shall remain available for ex-  
25 penditure through fiscal year 2015.

1           (3) RESERVATION.—Of the amount appro-  
 2       priated under paragraph (1), the Secretary shall re-  
 3       serve—

4                   (A) \$5,000,000 to carry out subsection (a);

5           and

6                   (B) \$25,000,000 to carry out subsection

7       (b), of which—

8                   (i) 2 percent shall be for the provision

9                   of technical assistance to grant recipients;

10          and

11                   (ii) 5 percent shall be for independent

12          evaluation under subsection (b)(7).

13   **SEC. 527. RURAL HEALTH CARE SERVICES.**

14       Section 330A of the Public Health Service Act (42  
 15   U.S.C. 254c) is amended to read as follows:

16   **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**

17                   **RURAL HEALTH NETWORK DEVELOPMENT,**

18                   **DELTA RURAL DISPARITIES AND HEALTH**

19                   **SYSTEMS DEVELOPMENT, AND SMALL RURAL**

20                   **HEALTH CARE PROVIDER QUALITY IMPROVE-**

21                   **MENT GRANT PROGRAMS.**

22       “(a) PURPOSE.—The purpose of this section is to  
 23   provide for grants—

24                   “(1) under subsection (b), to promote rural

25       health care services outreach;

1           “(2) under subsection (c), to provide for the  
2           planning and implementation of integrated health  
3           care networks in rural areas;

4           “(3) under subsection (d), to assist rural com-  
5           munities in the Delta Region to reduce health dis-  
6           parities and to promote and enhance health system  
7           development; and

8           “(4) under subsection (e), to provide for the  
9           planning and implementation of small rural health  
10          care provider quality improvement activities.

11          “(b) RURAL HEALTH CARE SERVICES OUTREACH  
12          GRANTS.—

13               “(1) GRANTS.—The Director of the Office of  
14          Rural Health Policy of the Health Resources and  
15          Services Administration may award grants to eligible  
16          entities to promote rural health care services out-  
17          reach by expanding the delivery of health care serv-  
18          ices to include new and enhanced services in rural  
19          areas. The Director may award the grants for peri-  
20          ods of not more than 3 years.

21               “(2) ELIGIBILITY.—To be eligible to receive a  
22          grant under this subsection for a project, an enti-  
23          ty—

24                       “(A) shall be a rural public or rural non-  
25          profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the  
2 Social Security Act, a public or nonprofit entity  
3 existing exclusively to provide services to mi-  
4 grant and seasonal farm workers in rural areas,  
5 or a tribal government whose grant-funded ac-  
6 tivities will be conducted within federally recog-  
7 nized tribal areas;

8 “(B) shall represent a consortium com-  
9 posed of members—

10 “(i) that include 3 or more independ-  
11 ently owned health care entities; and

12 “(ii) that may be nonprofit or for-  
13 profit entities; and

14 “(C) shall not previously have received a  
15 grant under this subsection for the same or a  
16 similar project, unless the entity is proposing to  
17 expand the scope of the project or the area that  
18 will be served through the project.

19 “(3) APPLICATIONS.—To be eligible to receive a  
20 grant under this subsection, an eligible entity shall  
21 prepare and submit to the Director an application at  
22 such time, in such manner, and containing such in-  
23 formation as the Director may require, including—

1           “(A) a description of the project that the  
2           eligible entity will carry out using the funds  
3           provided under the grant;

4           “(B) a description of the manner in which  
5           the project funded under the grant will meet  
6           the health care needs of rural populations in  
7           the local community or region to be served;

8           “(C) a plan for quantifying how health  
9           care needs will be met through identification of  
10          the target population and benchmarks of service  
11          delivery or health status, such as—

12               “(i) quantifiable measurements of  
13               health status improvement for projects fo-  
14               cusing on health promotion; or

15               “(ii) benchmarks of increased access  
16               to primary care, including tracking factors  
17               such as the number and type of primary  
18               care visits, identification of a medical  
19               home, or other general measures of such  
20               access;

21          “(D) a description of how the local com-  
22          munity or region to be served will be involved  
23          in the development and ongoing operations of  
24          the project;



1           “(E) a plan for sustaining the project after  
2           Federal support for the project has ended;

3           “(F) a description of how the project will  
4           be evaluated;

5           “(G) the administrative capacity to submit  
6           annual performance data electronically as speci-  
7           fied by the Director; and

8           “(H) other such information as the Direc-  
9           tor determines to be appropriate.

10       “(c) RURAL HEALTH NETWORK DEVELOPMENT  
11       GRANTS.—

12       “(1) GRANTS.—

13           “(A) IN GENERAL.—The Director may  
14           award rural health network development grants  
15           to eligible entities to promote, through planning  
16           and implementation, the development of inte-  
17           grated health care networks that have combined  
18           the functions of the entities participating in the  
19           networks in order to—

20           “(i) achieve efficiencies and economies  
21           of scale;

22           “(ii) expand access to, coordinate, and  
23           improve the quality of the health care de-  
24           livery system through development of orga-  
25           nizational efficiencies;

1                   “(iii) implement health information  
2                   technology to achieve efficiencies, reduce  
3                   medical errors, and improve quality;

4                   “(iv) coordinate care and manage  
5                   chronic illness; and

6                   “(v) strengthen the rural health care  
7                   system as a whole in such a manner as to  
8                   show a quantifiable return on investment  
9                   to the participants in the network.

10                  “(B) GRANT PERIODS.—The Director may  
11                  award such a rural health network development  
12                  grant—

13                       “(i) for a period of 3 years for imple-  
14                       mentation activities; or

15                       “(ii) for a period of 1 year for plan-  
16                       ning activities to assist in the initial devel-  
17                       opment of an integrated health care net-  
18                       work, if the proposed participants in the  
19                       network do not have a history of collabo-  
20                       rative efforts and a 3-year grant would be  
21                       inappropriate.

22                  “(2) ELIGIBILITY.—To be eligible to receive a  
23                  grant under this subsection, an entity—

24                       “(A) shall be a rural public or rural non-  
25                       profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the  
2 Social Security Act, a public or nonprofit entity  
3 existing exclusively to provide services to mi-  
4 grant and seasonal farm workers in rural areas,  
5 or a tribal government whose grant-funded ac-  
6 tivities will be conducted within federally recog-  
7 nized tribal areas;

8 “(B) shall represent a network composed  
9 of participants—

10 “(i) that include 3 or more independ-  
11 ently owned health care entities; and

12 “(ii) that may be nonprofit or for-  
13 profit entities; and

14 “(C) shall not previously have received a  
15 grant under this subsection (other than a 1-  
16 year grant for planning activities) for the same  
17 or a similar project.

18 “(3) APPLICATIONS.—To be eligible to receive a  
19 grant under this subsection, an eligible entity, in  
20 consultation with the appropriate State office of  
21 rural health or another appropriate State entity,  
22 shall prepare and submit to the Director an applica-  
23 tion at such time, in such manner, and containing  
24 such information as the Director may require, in-  
25 cluding—

1           “(A) a description of the project that the  
2 eligible entity will carry out using the funds  
3 provided under the grant;

4           “(B) an explanation of the reasons why  
5 Federal assistance is required to carry out the  
6 project;

7           “(C) a description of—

8               “(i) the history of collaborative activi-  
9 ties carried out by the participants in the  
10 network;

11               “(ii) the degree to which the partici-  
12 pants are ready to integrate their func-  
13 tions; and

14               “(iii) how the local community or re-  
15 gion to be served will benefit from and be  
16 involved in the activities carried out by the  
17 network;

18           “(D) a description of how the local com-  
19 munity or region to be served will experience in-  
20 creased access to quality health care services  
21 across the continuum of care as a result of the  
22 integration activities carried out by the net-  
23 work, including a description of—

24               “(i) return on investment for the com-  
25 munity and the network members; and

1                   “(ii) other quantifiable performance  
2                   measures that show the benefit of the net-  
3                   work activities;

4                   “(E) a plan for sustaining the project after  
5                   Federal support for the project has ended;

6                   “(F) a description of how the project will  
7                   be evaluated;

8                   “(G) the administrative capacity to submit  
9                   annual performance data electronically as speci-  
10                  fied by the Director; and

11                  “(H) other such information as the Direc-  
12                  tor determines to be appropriate.

13                  “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-  
14                  TEMS DEVELOPMENT GRANTS.—

15                  “(1) GRANTS.—The Director may award grants  
16                  to eligible entities to support reduction of health dis-  
17                  parities, improve access to health care, and enhance  
18                  rural health system development in the Delta Re-  
19                  gion.

20                  “(2) ELIGIBILITY.—To be eligible to receive a  
21                  grant under this subsection, an entity shall be a  
22                  rural public or rural nonprofit private entity, a facil-  
23                  ity that qualifies as a rural health clinic under title  
24                  XVIII of the Social Security Act, a public or non-  
25                  profit entity existing exclusively to provide services

1 to migrant and seasonal farm workers in rural  
2 areas, or a tribal government whose grant-funded  
3 activities will be conducted within federally recog-  
4 nized tribal areas.

5 “(3) APPLICATIONS.—To be eligible to receive a  
6 grant under this subsection, an eligible entity shall  
7 prepare and submit to the Director an application at  
8 such time, in such manner, and containing such in-  
9 formation as the Director may require, including—

10 “(A) a description of the project that the  
11 eligible entity will carry out using the funds  
12 provided under the grant;

13 “(B) an explanation of the reasons why  
14 Federal assistance is required to carry out the  
15 project;

16 “(C) a description of the manner in which  
17 the project funded under the grant will meet  
18 the health care needs of the Delta Region;

19 “(D) a description of how the local com-  
20 munity or region to be served will experience in-  
21 creased access to quality health care services as  
22 a result of the activities carried out by the enti-  
23 ty;

1           “(E) a description of how health dispari-  
2           ties will be reduced or the health system will be  
3           improved;

4           “(F) a plan for sustaining the project after  
5           Federal support for the project has ended;

6           “(G) a description of how the project will  
7           be evaluated including process and outcome  
8           measures related to the quality of care provided  
9           or how the health care system improves its per-  
10          formance;

11          “(H) a description of how the grantee will  
12          develop an advisory group made up of rep-  
13          resentatives of the communities to be served to  
14          provide guidance to the grantee to best meet  
15          community need; and

16          “(I) other such information as the Director  
17          determines to be appropriate.

18          “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-  
19          ITY IMPROVEMENT GRANTS.—

20               “(1) GRANTS.—The Director may award grants  
21               to provide for the planning and implementation of  
22               small rural health care provider quality improvement  
23               activities. The Director may award the grants for  
24               periods of 1 to 3 years.

1           “(2) ELIGIBILITY.—To be eligible for a grant  
2 under this subsection, an entity—

3           “(A) shall be—

4           “(i) a rural public or rural nonprofit  
5 private health care provider or provider of  
6 health care services, such as a rural health  
7 clinic; or

8           “(ii) another rural provider or net-  
9 work of small rural providers identified by  
10 the Director as a key source of local care;  
11 and

12           “(B) shall not previously have received a  
13 grant under this subsection for the same or a  
14 similar project.

15           “(3) PREFERENCE.—In awarding grants under  
16 this subsection, the Director shall give preference to  
17 facilities that qualify as rural health clinics under  
18 title XVIII of the Social Security Act.

19           “(4) APPLICATIONS.—To be eligible to receive a  
20 grant under this subsection, an eligible entity shall  
21 prepare and submit to the Director an application at  
22 such time, in such manner, and containing such in-  
23 formation as the Director may require, including—



1           “(A) a description of the project that the  
2           eligible entity will carry out using the funds  
3           provided under the grant;

4           “(B) an explanation of the reasons why  
5           Federal assistance is required to carry out the  
6           project;

7           “(C) a description of the manner in which  
8           the project funded under the grant will assure  
9           continuous quality improvement in the provision  
10          of services by the entity;

11          “(D) a description of how the local com-  
12          munity or region to be served will experience in-  
13          creased access to quality health care services as  
14          a result of the activities carried out by the enti-  
15          ty;

16          “(E) a plan for sustaining the project after  
17          Federal support for the project has ended;

18          “(F) a description of how the project will  
19          be evaluated including process and outcome  
20          measures related to the quality of care pro-  
21          vided; and

22          “(G) other such information as the Direc-  
23          tor determines to be appropriate.

24          “(f) GENERAL REQUIREMENTS.—

1           “(1) PROHIBITED USES OF FUNDS.—An entity  
2           that receives a grant under this section may not use  
3           funds provided through the grant—

4                   “(A) to build or acquire real property; or  
5                   “(B) for construction.

6           “(2) COORDINATION WITH OTHER AGENCIES.—  
7           The Director shall coordinate activities carried out  
8           under grant programs described in this section, to  
9           the extent practicable, with Federal and State agen-  
10          cies and nonprofit organizations that are operating  
11          similar grant programs, to maximize the effect of  
12          public dollars in funding meritorious proposals.

13          “(g) REPORT.—Not later than September 30, 2012,  
14          the Secretary shall prepare and submit to the appropriate  
15          committees of Congress a report on the progress and ac-  
16          complishments of the grant programs described in sub-  
17          sections (b), (c), (d), and (e).

18          “(h) DEFINITIONS.—In this section:

19                  “(1) The term ‘Delta Region’ has the meaning  
20                  given to the term ‘region’ in section 382A of the  
21                  Consolidated Farm and Rural Development Act (7  
22                  U.S.C. 2009aa).

23                  “(2) The term ‘Director’ means the Director of  
24                  the Office of Rural Health Policy of the Health Re-  
25                  sources and Services Administration.

1       “(i) AUTHORIZATION OF APPROPRIATIONS.—There  
2 are authorized to be appropriated to carry out this section  
3 \$40,000,000 for fiscal year 2010, and such sums as may  
4 be necessary for each of fiscal years 2011 through 2014.”.

5   **SEC. 528. COMMUNITY HEALTH CENTER COLLABORATIVE**  
6                   **ACCESS EXPANSION.**

7       Section 330 of the Public Health Service Act (42  
8 U.S.C. 254b) is amended by adding at the end the fol-  
9 lowing:

10       “(s) MISCELLANEOUS PROVISIONS.—

11               “(1) RULE OF CONSTRUCTION WITH RESPECT  
12 TO RURAL HEALTH CLINICS.—

13               “(A) IN GENERAL.—Nothing in this sec-  
14 tion shall be construed to prevent a community  
15 health center from contracting with a federally  
16 certified rural health clinic (as defined by sec-  
17 tion 1861(aa)(2) of the Social Security Act) for  
18 the delivery of primary health care services that  
19 are available at the rural health clinic to indi-  
20 viduals who would otherwise be eligible for free  
21 or reduced cost care if that individual were able  
22 to obtain that care at the community health  
23 center. Such services may be limited in scope to  
24 those primary health care services available in  
25 that rural health clinic.

1           “(B) ASSURANCES.—In order for a rural  
 2           health clinic to receive funds under this section  
 3           through a contract with a community health  
 4           center under paragraph (1), such rural health  
 5           clinic shall establish policies to ensure—

6                       “(i) nondiscrimination based upon the  
 7                       ability of a patient to pay; and

8                       “(ii) the establishment of a sliding fee  
 9                       scale for low-income patients.”.

10 **SEC. 529. FACILITATING THE PROVISION OF TELEHEALTH**  
 11 **SERVICES ACROSS STATE LINES.**

12       (a) IN GENERAL.—For purposes of expediting the  
 13 provision of telehealth services, for which payment is made  
 14 under the Medicare program, across State lines, the Sec-  
 15 retary of Health and Human Services shall, in consulta-  
 16 tion with representatives of States, physicians, health care  
 17 practitioners, and patient advocates, encourage and facili-  
 18 tate the adoption of provisions allowing for multistate  
 19 practitioner practice across State lines.

20       (b) DEFINITIONS.—In subsection (a):

21           (1) TELEHEALTH SERVICE.—The term “tele-  
 22 health service” has the meaning given that term in  
 23 subparagraph (F) of section 1834(m)(4) of the So-  
 24 cial Security Act (42 U.S.C. 1395m(m)(4)).

1           (2) PHYSICIAN, PRACTITIONER.—The terms  
2       “physician” and “practitioner” have the meaning  
3       given those terms in subparagraphs (D) and (E), re-  
4       spectively, of such section.

5           (3) MEDICARE PROGRAM.—The term “Medicare  
6       program” means the program of health insurance  
7       administered by the Secretary of Health and Human  
8       Services under title XVIII of the Social Security Act  
9       (42 U.S.C. 1395 et seq.).

10 **SEC. 530. REMOVING BARRIERS TO HEALTH CARE AND NU-**  
11 **TRITION ASSISTANCE HEALTH COVERAGE**  
12 **FOR CHILDREN, PREGNANT WOMEN, AND**  
13 **LAWFULLY RESIDING INDIVIDUALS.**

14       (a) MEDICAID.—Section 1903(v) of the Social Secu-  
15 rity Act (42 U.S.C. 1396b(v)) is amended by striking  
16 paragraph (4) and inserting the following new paragraph:

17       “(4)(A) Notwithstanding sections 401(a), 402(b),  
18 403, and 421 of the Personal Responsibility and Work Op-  
19 portunity Reconciliation Act of 1996, payment shall be  
20 made under this section for care and services that are fur-  
21 nished to individuals, including those described in para-  
22 graph (1), if they otherwise meet the eligibility require-  
23 ments for medical assistance under the State plan ap-  
24 proved under this title (other than the requirement of the  
25 receipt of aid or assistance under title IV, supplemental

1 security income benefits under title XVI, or a State sup-  
2 plementary payment), and are—

3 “(i) lawfully present in the United States;

4 “(ii) children under age 21, including optional  
5 targeted low-income children described in section  
6 1905(u)(2)(B); or

7 “(iii) pregnant women during pregnancy (and  
8 during the 60-day period beginning on the last day  
9 of the pregnancy).

10 “(B) No debt shall accrue under an affidavit of sup-  
11 port against any sponsor of such an alien on the basis  
12 of provision of assistance to such category and the cost  
13 of such assistance shall not be considered as an unreim-  
14 bursed cost.”.

15 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-  
16 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by striking  
17 subparagraph (H) and inserting the following new sub-  
18 paragraph:

19 “(H) Paragraph (4) of section 1903(v) (re-  
20 lating to individuals who, but for sections  
21 401(a), 403, and 421 of the Personal Responsi-  
22 bility and Work Opportunity Reconciliation Act  
23 of 1996, would be eligible for medical assistance  
24 under title XXI).”.

25 (c) NUTRITION ASSISTANCE.—

1           (1) SUPPLEMENTAL NUTRITION ASSISTANCE.—  
2       Notwithstanding sections 401(a), 402(a), and 403(a)  
3       of the Personal Responsibility and Work Oppor-  
4       tunity Reconciliation Act of 1996 (8 U.S.C. 1611(a);  
5       1612(a), 1613(a)) and section 6(f) of the Food and  
6       Nutrition Act of 2008 (7 U.S.C. 2015(f)), persons  
7       who are lawfully present in the United States shall  
8       be not be ineligible for benefits under the supple-  
9       mental nutrition assistance program on the basis of  
10      their immigration status or date of entry into the  
11      United States.

12          (2) ELIGIBILITY FOR FAMILIES WITH CHIL-  
13      DREN.—Section of the 421(d)(3) of the Personal Re-  
14      sponsibility and Work Opportunity Reconciliation  
15      Act of 1996 (8 U.S.C. 1631(d)(3)) is amended by  
16      striking “to the extent that a qualified alien is eligi-  
17      ble under section 402(a)(2)(J)” and inserting, “to  
18      the extent that a child is a member of a household  
19      under the supplemental nutrition assistance pro-  
20      gram”.

21          (3) ENSURING PROPER SCREENING.—Section  
22      11(e)(2)(B) of the Food and Nutrition Act of 2008  
23      (7 U.S.C. 2020(e)(2)(B)) is amended—

24              (A) by redesignating clauses (vi) and (viii)  
25      as clauses (vii) and (viii); and

1 (B) by inserting after clause (v) the fol-  
 2 lowing:

3 “(vi) shall provide a method for imple-  
 4 menting section 421 of the Personal Re-  
 5 sponsibility and Work Opportunity Rec-  
 6 onciliation Act of 1996 (8 U.S.C. 1631)  
 7 that does not require any unnecessary in-  
 8 formation from persons who may be ex-  
 9 empt from that provision;”.

10 **SEC. 531. REMOVING MEDICARE BARRIER TO HEALTH**  
 11 **CARE.**

12 Section 1818(a)(3) of the Social Security Act (42  
 13 U.S.C. 1395i–2(a)(3)) is amended by amending clause (B)  
 14 to read as follows: “(B) an individual who is lawfully  
 15 present in the United States”.

16 **CHAPTER 2—LUNG CANCER MORTALITY**  
 17 **REDUCTION**

18 **SEC. 541. SHORT TITLE.**

19 This chapter may be cited as the “Lung Cancer Mor-  
 20 tality Reduction Act of 2009”.

21 **SEC. 542. FINDINGS.**

22 Congress makes the following findings:

23 (1) Lung cancer is the leading cause of cancer  
 24 death for both men and women, accounting for 28  
 25 percent of all cancer deaths.



1           (2) Lung cancer kills more people annually  
2           than breast cancer, prostate cancer, colon cancer,  
3           liver cancer, melanoma, and kidney cancer combined.

4           (3) Since the National Cancer Act of 1971  
5           (Public Law 92–218; 85 Stat. 778), coordinated and  
6           comprehensive research has raised the 5-year sur-  
7           vival rates for breast cancer to 88 percent, for pros-  
8           tate cancer to 99 percent, and for colon cancer to  
9           64 percent.

10          (4) However, the 5-year survival rate for lung  
11          cancer is still only 15 percent and a similar coordi-  
12          nated and comprehensive research effort is required  
13          to achieve increases in lung cancer survivability  
14          rates.

15          (5) Sixty percent of lung cancer cases are now  
16          diagnosed as nonsmokers or former smokers.

17          (6) Two-thirds of nonsmokers diagnosed with  
18          lung cancer are women.

19          (7) Certain minority populations, such as Afri-  
20          can-American males, have disproportionately high  
21          rates of lung cancer incidence and mortality, not-  
22          withstanding their similar smoking rate.

23          (8) Members of the baby boomer generation are  
24          entering their sixties, the most common age at which  
25          people develop lung cancer.

1           (9) Tobacco addiction and exposure to other  
2           lung cancer carcinogens such as Agent Orange and  
3           other herbicides and battlefield emissions are serious  
4           problems among military personnel and war vet-  
5           erans.

6           (10) Significant and rapid improvements in  
7           lung cancer mortality can be expected through great-  
8           er use and access to lung cancer screening tests for  
9           at-risk individuals.

10          (11) Additional strategies are necessary to fur-  
11          ther enhance the existing tests and therapies avail-  
12          able to diagnose and treat lung cancer in the future.

13          (12) The August 2001 Report of the Lung  
14          Cancer Progress Review Group of the National Can-  
15          cer Institute stated that funding for lung cancer re-  
16          search was “far below the levels characterized for  
17          other common malignancies and far out of propor-  
18          tion to its massive health impact”.

19          (13) The Report of the Lung Cancer Progress  
20          Review Group identified as its “highest priority” the  
21          creation of integrated, multidisciplinary, multi-insti-  
22          tutional research consortia organized around the  
23          problem of lung cancer rather than around specific  
24          research disciplines.

1           (14) The United States must enhance its re-  
 2           sponse to the issues raised in the Report of the  
 3           Lung Cancer Progress Review Group, and this can  
 4           be accomplished through the establishment of a co-  
 5           ordinated effort designed to reduce the lung cancer  
 6           mortality rate by 50 percent by 2015 and targeted  
 7           funding to support this coordinated effort.

8   **SEC. 543. SENSE OF CONGRESS CONCERNING INVESTMENT**  
 9                           **IN LUNG CANCER RESEARCH.**

10          It is the sense of the Congress that—

11               (1) lung cancer mortality reduction should be  
 12               made a national public health priority; and

13               (2) a comprehensive mortality reduction pro-  
 14               gram coordinated by the Secretary of Health and  
 15               Human Services is justified and necessary to ade-  
 16               quately address and reduce lung cancer mortality.

17   **SEC. 544. LUNG CANCER MORTALITY REDUCTION PRO-**  
 18                           **GRAM.**

19          (a) IN GENERAL.—Subpart 1 of part C of title IV  
 20          of the Public Health Service Act (42 U.S.C. 285 et seq.)  
 21          is amended by adding at the end the following:

22   **“SEC. 417G. LUNG CANCER MORTALITY REDUCTION PRO-**  
 23                           **GRAM.**

24          “(a) IN GENERAL.—Not later than 6 months after  
 25          the date of the enactment of this section, the Secretary,

1 in consultation with the Secretary of Defense, the Sec-  
2 retary of Veterans Affairs, the Director of the National  
3 Institutes of Health, the Director of the Centers for Dis-  
4 ease Control and Prevention, the Commissioner of Food  
5 and Drugs, the Administrator of the Centers for Medicare  
6 & Medicaid Services, the Director of the National Center  
7 on Minority Health and Health Disparities, and other  
8 members of the Lung Cancer Advisory Board established  
9 under section 546 of the Lung Cancer Mortality Reduc-  
10 tion Act of 2009, shall implement a comprehensive pro-  
11 gram, to be known as the Lung Cancer Mortality Reduc-  
12 tion Program, to achieve a reduction of at least 25 percent  
13 in the mortality rate of lung cancer by 2015.

14 “(b) REQUIREMENTS.—The Program shall include at  
15 least the following:

16 “(1) With respect to the National Institutes of  
17 Health—

18 “(A) a strategic review and prioritization  
19 by the National Cancer Institute of research  
20 grants to achieve the goal of the Lung Cancer  
21 Mortality Reduction Program in reducing lung  
22 cancer mortality;

23 “(B) the provision of funds to enable the  
24 Airway Biology and Disease Branch of the Na-  
25 tional Heart, Lung, and Blood Institute to ex-

1           pand its research programs to include pre-  
2           dispositions to lung cancer, the interrelationship  
3           between lung cancer and other pulmonary and  
4           cardiac disease, and the diagnosis and treat-  
5           ment of these interrelationships;

6           “(C) the provision of funds to enable the  
7           National Institute of Biomedical Imaging and  
8           Bioengineering to expedite the development of  
9           computer assisted diagnostic, surgical, treat-  
10          ment, and drug testing innovations to reduce  
11          lung cancer mortality, such as through expan-  
12          sion of the Institute’s Quantum Grant Program  
13          and Image-Guided Interventions programs; and

14          “(D) the provision of funds to enable the  
15          National Institute of Environmental Health  
16          Sciences to implement research programs rel-  
17          ative to the lung cancer incidence.

18          “(2) With respect to the Food and Drug Ad-  
19          ministration—

20               “(A) activities under section 529 of the  
21               Federal Food, Drug, and Cosmetic Act; and

22               “(B) activities under section 561 of the  
23               Federal Food, Drug, and Cosmetic Act to ex-  
24               pand access to investigational drugs and devices

1           for the diagnosis, monitoring, or treatment of  
2           lung cancer.

3           “(3) With respect to the Centers for Disease  
4           Control and Prevention, the establishment of an  
5           early disease research and management program  
6           under section 1511.

7           “(4) With respect to the Agency for Healthcare  
8           Research and Quality, the conduct of a biannual re-  
9           view of lung cancer screening, diagnostic, and treat-  
10          ment protocols, and the issuance of updated guide-  
11          lines.

12          “(5) The cooperation and coordination of all  
13          minority and health disparity programs within the  
14          Department of Health and Human Services to en-  
15          sure that all aspects of the Lung Cancer Mortality  
16          Reduction Program under this section adequately  
17          address the burden of lung cancer on minority and  
18          rural populations.

19          “(6) The cooperation and coordination of all to-  
20          bacco control and cessation programs within agen-  
21          cies of the Department of Health and Human Serv-  
22          ices to achieve the goals of the Lung Cancer Mor-  
23          tality Reduction Program under this section with  
24          particular emphasis on the coordination of drug and

1 other cessation treatments with early detection pro-  
2 tocols.”.

3 (b) FEDERAL FOOD, DRUG, AND COSMETIC ACT.—  
4 Subchapter B of chapter V of the Federal Food, Drug,  
5 and Cosmetic Act (21 U.S.C. 360aaa et seq.) is amended  
6 by adding at the end the following:

7 “DRUGS RELATING TO LUNG CANCER

8 “SEC. 529. (a) IN GENERAL.—The provisions of this  
9 subchapter shall apply to a drug described in subsection  
10 (b) to the same extent and in the same manner as such  
11 provisions apply to a drug for a rare disease or condition.

12 “(b) QUALIFIED DRUGS.—A drug described in this  
13 subsection is—

14 “(1) a chemoprevention drug for precancerous  
15 conditions of the lung;

16 “(2) a drug for a targeted therapeutic treat-  
17 ments, including any vaccine for, lung cancer; and

18 “(3) a drug to curtail or prevent nicotine addic-  
19 tion.

20 “(c) BOARD.—The Board established under section  
21 546 of the Lung Cancer Mortality Reduction Act of 2009  
22 shall monitor the program implemented under this sec-  
23 tion.”.

24 (c) ACCESS TO UNAPPROVED THERAPIES.—Section  
25 561(e) of the Federal Food, Drug, and Cosmetic Act (21  
26 U.S.C. 360bbb(e)) is amended by inserting before the pe-

1 riod the following: “and shall include expanding access to  
2 drugs under section 529, with substantial consideration  
3 being given to whether the totality of information available  
4 to the Secretary regarding the safety and effectiveness of  
5 an investigational drug, as compared to the risk of mor-  
6 bidity and death from the disease, indicates that a patient  
7 may obtain more benefit than risk if treated with the  
8 drug”.

9 (d) CDC.—Title XV of the Public Health Service Act  
10 (42 U.S.C. 300k et seq.) is amended by adding at the end  
11 the following:

12 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**  
13 **PROGRAM.**

14 “The Secretary shall establish and implement an  
15 early disease research and management program targeted  
16 at the high incidence and mortality rates of lung cancer  
17 among minority and low-income populations.”.

18 **SEC. 545. DEPARTMENT OF DEFENSE AND THE DEPART-**  
19 **MENT OF VETERANS AFFAIRS.**

20 The Secretary of Defense and the Secretary of Vet-  
21 erans Affairs shall coordinate with the Secretary of Health  
22 and Human Services—

23 (1) in the development of the Lung Cancer  
24 Mortality Reduction Program under section 417G;



1           (2) in the implementation within the Depart-  
2           ment of Defense and the Department of Veterans  
3           Affairs of an early detection and disease manage-  
4           ment research program for military personnel and  
5           veterans whose smoking history and exposure to car-  
6           cinogens during active duty service has increased  
7           their risk for lung cancer; and

8           (3) in the implementation of coordinated care  
9           programs for military personnel and veterans diag-  
10          nosed with lung cancer.

11 **SEC. 546. LUNG CANCER ADVISORY BOARD.**

12          (a) IN GENERAL.—The Secretary of Health and  
13          Human Services shall convene a Lung Cancer Advisory  
14          Board (referred to in this section as the “Board”)—

15               (1) to monitor the programs established under  
16               this chapter (and the amendments made by this  
17               chapter); and

18               (2) to provide annual reports to the Congress  
19               concerning benchmarks, expenditures, lung cancer  
20               statistics, and the public health impact of such pro-  
21               grams.

22          (b) COMPOSITION.—The Board shall be composed  
23          of—

24               (1) the Secretary of Health and Human Serv-  
25               ices;

1           (2) the Secretary of Defense;

2           (3) the Secretary of Veterans Affairs; and

3           (4) two representatives each from the fields of  
4       clinical medicine focused on lung cancer, lung cancer  
5       research, imaging, drug development, and lung can-  
6       cer advocacy, to be appointed by the Secretary of  
7       Health and Human Services.

8   **SEC. 547. AUTHORIZATION OF APPROPRIATIONS.**

9       (a) IN GENERAL.—To carry out this chapter (and the  
10   amendments made by this chapter), there are authorized  
11   to be appropriated such sums as may be necessary for  
12   each of fiscal years 2010 through 2014.

13       (b) LUNG CANCER MORTALITY REDUCTION PRO-  
14   GRAM.—Of the amounts authorized to be appropriated by  
15   subsection (a), there are authorized to be appropriated—

16           (1) \$25,000,000 for fiscal year 2010, and such  
17       sums as may be necessary for each of fiscal years  
18       2011 through 2014, for the activities described in  
19       section 417G(b)(1)(B) of the Public Health Service  
20       Act, as added by section 544(a);

21           (2) \$25,000,000 for fiscal year 2010, and such  
22       sums as may be necessary for each of fiscal years  
23       2011 through 2014, for the activities described in  
24       section 417G(b)(1)(C) of such Act;

1           (3) \$10,000,000 for fiscal year 2010, and such  
 2       sums as may be necessary for each of fiscal years  
 3       2011 through 2014, for the activities described in  
 4       section 417G(b)(1)(D) of such Act; and

5           (4) \$15,000,000 for fiscal year 2010, and such  
 6       sums as may be necessary for each of fiscal years  
 7       2011 through 2014, for the activities described in  
 8       section 417G(b)(3) of such Act.

9       **TITLE VI—ELIMINATING DIS-**  
 10       **PARITIES IN DIABETES PRE-**  
 11       **VENTION ACCESS AND CARE**  
 12       **ACT**

13               **Subtitle A—NATIONAL**  
 14               **INSTITUTES OF HEALTH**

15       **SEC. 611. RESEARCH, TREATMENT, AND EDUCATION.**

16       (a) IN GENERAL.—Subpart 3 of part C of title IV  
 17       of the Public Health Service Act (42 U.S.C. 285c et seq.)  
 18       is amended by adding at the end the following new section:

19       **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

20       “(a) IN GENERAL.—The Director of the National In-  
 21       stitutes of Health shall expand, intensify, and support on-  
 22       going research and other activities with respect to pre-dia-  
 23       betes and diabetes, particularly type 2, in minority popu-  
 24       lations, including research to identify clinical, socio-

1 economic, geographical, cultural, and organizational fac-  
2 tors that contribute to type 2 diabetes in such populations.

3 “(b) CERTAIN ACTIVITIES.—Activities under sub-  
4 section (a) regarding type 2 diabetes in minority popu-  
5 lations shall include the following:

6 “(1) Continue research on behavior and obesity,  
7 including research through the obesity research cen-  
8 ter that is sponsored by the National Institutes of  
9 Health.

10 “(2) Research on environmental factors that  
11 may contribute to the increase in type 2 diabetes.

12 “(3) Support for new methods to identify envi-  
13 ronmental triggers and genetic interactions that lead  
14 to the development of type 2 diabetes in minority  
15 newborns. Such research should follow the newborns  
16 through puberty, an increasingly high-risk period for  
17 developing type 2 diabetes.

18 “(4) Research to identify genes that predispose  
19 individuals to the onset of developing type 1 and  
20 type 2 diabetes and to the development of complica-  
21 tions.

22 “(5) Research to prevent complications in indi-  
23 viduals who have already developed diabetes, such as  
24 research that attempts to identify the genes that

1 predispose individuals with diabetes to the develop-  
2 ment of complications.

3 “(6) Research methods and alternative thera-  
4 pies to control blood glucose.

5 “(7) Support of ongoing research efforts exam-  
6 ining the level of glycemia at which adverse out-  
7 comes develop during pregnancy and to address the  
8 many clinical issues associated with minority moth-  
9 ers and fetuses during diabetic and gestational dia-  
10 betic pregnancies.

11 “(c) EDUCATION.—The Director of the National In-  
12 stitutes of Health shall—

13 “(1) through the National Center on Minority  
14 Health and Health Disparities and the National Di-  
15 abetes Education Program—

16 “(A) make grants to programs funded  
17 under section 485F (relating to centers of ex-  
18 cellence) for the purpose of establishing a men-  
19 toring program for health care professionals to  
20 be more involved in weight counseling, obesity  
21 research, and nutrition; and

22 “(B) provide for the participation of mi-  
23 nority health professionals in diabetes-focused  
24 research programs; and

1           “(2) make grants for programs to establish a  
2           pipeline from high school to professional school that  
3           will increase minority representation in diabetes-foc-  
4           cused health fields by expanding Minority Access to  
5           Research Careers (MARC) program internships and  
6           mentoring opportunities for recruitment.

7           “(d) DEFINITION.—For purposes of this section, the  
8           term ‘minority population’ means a racial and ethnic mi-  
9           nority group, as defined in section 1707.

10          “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
11          purpose of carrying out this section, there are authorized  
12          to be appropriated such sums as are necessary for fiscal  
13          year 2010 and each subsequent fiscal year.”.

14          (b) DIABETES MELLITUS INTERAGENCY COORDI-  
15          NATING COMMITTEE.—Section 429 of the Public Health  
16          Service Act (42 U.S.C. 285c–3) is amended by adding at  
17          the end the following new subsection:

18          “(c)(1) In each annual report prepared by the Diabe-  
19          tes Mellitus Interagency Coordinating Committee, the  
20          Committee shall include an assessment of the Federal ac-  
21          tivities and programs related to diabetes in minority popu-  
22          lations. Such assessment shall—

23                  “(A) compile the current activities of all  
24                  current Federal health programs to allow for  
25                  the assessment of their adequacy as a systemic

1 method of addressing the impact of diabetes  
2 mellitus on minority populations;

3 “(B) develop strategic planning activities  
4 to develop an effective and comprehensive Fed-  
5 eral plan to address diabetes mellitus within mi-  
6 nority populations which will involve all appro-  
7 priate Federal health programs and shall—

8 “(i) include steps to address issues in-  
9 cluding type 1 and type 2 diabetes in chil-  
10 dren and the disproportionate impact of di-  
11 abetes mellitus on minority populations;  
12 and

13 “(ii) remain consistent with the pro-  
14 grams and activities identified in section  
15 3990, as well as remaining consistent with  
16 the intent of the Eliminating Disparities in  
17 Diabetes Prevention Access and Care Act  
18 of 2009; and

19 “(C) assess the implementation of such a  
20 plan throughout Federal health programs.

21 “(2) For the purposes of this subsection, the  
22 term ‘minority population’ means a racial and ethnic  
23 minority group, as defined in section 1707.

24 “(3) For the purpose of carrying out this sub-  
25 section, there are authorized to be appropriated such

1        sums as are necessary for fiscal year 2010 and each  
2        subsequent fiscal year.”.

3        **Subtitle B—CENTERS FOR DIS-**  
4        **EASE CONTROL AND PREVEN-**  
5        **TION**

6        **SEC. 621. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

7        Part B of title III of the Public Health Service Act  
8        (42 U.S.C. 243 et seq.) is amended by inserting after sec-  
9        tion 317T the following section:

10       **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

11       “(a) RESEARCH AND OTHER ACTIVITIES.—

12                “(1) IN GENERAL.—The Secretary, acting  
13        through the Director of the Centers for Disease  
14        Control and Prevention, shall conduct and support  
15        research and other activities with respect to diabetes  
16        in minority populations.

17                “(2) CERTAIN ACTIVITIES.—Activities under  
18        paragraph (1) regarding diabetes in minority popu-  
19        lations shall include the following:

20                        “(A) Expanding the National Diabetes  
21        Laboratory capacity for translational research  
22        and the identification of genetic and  
23        immunological risk factors associated with dia-  
24        betes.



1           “(B) Enhancing the National Health and  
2           Nutrition Examination Survey to include risk  
3           factors for type 2 diabetes and pre-diabetes  
4           with emphasis on eating and dietary habits, and  
5           focus, including cultural and socioeconomic fac-  
6           tors, on Hispanic-American, African-American,  
7           American Indian and Alaskan Native, and  
8           Asian-American, Native Hawaiian and other  
9           Pacific Islander communities.

10           “(C) Further enhancing the National  
11           Health and Nutrition Examination Survey by  
12           over-sampling Asian-American, Native Hawai-  
13           ian, and Other Pacific Islanders in appropriate  
14           geographic areas to better determine the preva-  
15           lence of diabetes in such populations as well as  
16           to improve the data collection of diabetes pene-  
17           tration disaggregated into major ethnic groups  
18           within such populations.

19           “(D) Within the Division of Diabetes  
20           Translation, providing for prevention research  
21           to better understand how to influence health  
22           care systems changes to improve quality of care  
23           being delivered to such populations, and within  
24           the Division of Diabetes Translation, carrying  
25           out model demonstration projects to design, im-

1           plement, and evaluate effective diabetes preven-  
2           tion and control intervention for such popu-  
3           lations.

4           “(E) Through the Division of Diabetes  
5           Translation, carrying out culturally appropriate  
6           community-based interventions designed to ad-  
7           dress issues and problems experienced by such  
8           populations.

9           “(F) Conducting applied research within  
10          the Division of Diabetes Translation to reduce  
11          health disparities within such populations with  
12          diabetes.

13          “(G) Conducting applied research on pri-  
14          mary prevention within the Division of Diabetes  
15          Translation to specifically focus on such popu-  
16          lations with pre-diabetes.

17       “(b) EDUCATION.—

18           “(1) IN GENERAL.—The Secretary, acting  
19           through the Director of the Centers for Disease  
20           Control and Prevention, shall direct the Division of  
21           Diabetes Translation to conduct and support pro-  
22           grams to educate the public on the causes and ef-  
23           fects of diabetes in minority populations.

24           “(2) CERTAIN ACTIVITIES.—Programs under  
25           paragraph (1) regarding education on diabetes in

1 minority populations shall include carrying out pub-  
2 lic awareness campaigns directed toward such popu-  
3 lations to aggressively emphasize the importance and  
4 impact of physical activity and diet in regard to dia-  
5 betes and diabetes-related complications through the  
6 National Diabetes Education Program.

7 “(c) DIABETES; HEALTH PROMOTION, PREVENTION  
8 ACTIVITIES, AND ACCESS.—

9 “(1) IN GENERAL.—The Secretary, acting  
10 through the Director of the Centers for Disease  
11 Control and Prevention, shall carry out culturally  
12 appropriate diabetes health promotion and preven-  
13 tion programs for minority populations.

14 “(2) CERTAIN ACTIVITIES.—Activities regard-  
15 ing culturally appropriate diabetes health promotion  
16 and prevention programs for minority populations  
17 shall include the following:

18 “(A) Expanding the Diabetes Prevention  
19 and Control Program (currently existing in all  
20 the States and territories) and providing funds  
21 for education and community outreach on dia-  
22 betes.

23 “(B) Providing funds for an expansion of  
24 the Diabetes Prevention Program Initiative that  
25 focuses on physical inactivity and diet and its

1 relation to type 2 diabetes within such popu-  
 2 lations.

3 “(C) Providing funds to strengthen exist-  
 4 ing surveillance systems to improve the quality,  
 5 accuracy, and timeliness of morbidity and mor-  
 6 tality diabetes data for such populations.

7 “(d) DEFINITION.—For purposes of this section, the  
 8 term ‘minority population’ means a racial and ethnic mi-  
 9 nority group, as defined in section 1707.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
 11 purpose of carrying out this section, there are authorized  
 12 to be appropriated such sums as are necessary for fiscal  
 13 year 2010 and each subsequent fiscal year.”.

14 **Subtitle C—HEALTH RESOURCES**  
 15 **AND SERVICES ADMINISTRA-**  
 16 **TION**

17 **SEC. 631. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

18 Part P of title III of the Public Health Service Act,  
 19 as amended, is amended by adding at the end the following  
 20 new section:

21 **“SEC. 399V. PROGRAMS TO EDUCATE HEALTH PROVIDERS**  
 22 **ON THE CAUSES AND EFFECTS OF DIABETES**  
 23 **IN MINORITY POPULATIONS.**

24 “(a) IN GENERAL.—The Secretary, acting through  
 25 the Director of the Health Resources and Services Admin-

1 istration, shall conduct and support programs described  
2 in subsection (b) to educate health professionals on the  
3 causes and effects of diabetes in minority populations.

4 “(b) PROGRAMS.—Programs described in this sub-  
5 section, with respect to education on diabetes in minority  
6 populations, shall include the following:

7 “(1) Making grants for diabetes-focused edu-  
8 cation classes or training programs on cultural sen-  
9 sitivity and patient care within such populations for  
10 health care providers.

11 “(2) Providing funds to community health cen-  
12 ters for programs that provide diabetes services and  
13 screenings.

14 “(3) Providing additional funds for the Health  
15 Careers Opportunity Program, Centers for Excel-  
16 lence, and the Minority Faculty Fellowship Program  
17 to partner with the Office of Minority Health under  
18 section 1707 and the National Institutes of Health  
19 to strengthen programs for career opportunities  
20 within minority populations focused on diabetes  
21 treatment and care.

22 “(4) Developing a diabetes focus within, and  
23 providing additional funds for, the National Health  
24 Service Corps Scholarship program to place individ-  
25 uals in areas that are disproportionately affected by

1 diabetes and to provide health care services to such  
2 areas.

3 “(5) Establishing a diabetes ambassador pro-  
4 gram for recruitment efforts to increase the number  
5 of underrepresented minorities currently serving in  
6 student, faculty, or administrative positions in insti-  
7 tutions of higher learning, hospitals, and community  
8 health centers.

9 “(6) Establishing a loan repayment program  
10 that focuses on diabetes care and prevention in mi-  
11 nority populations.”.

## 12 **Subtitle D—ADDITIONAL** 13 **PROGRAMS**

### 14 **SEC. 641. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

15 Part P of title III of the Public Health Service Act  
16 (42 U.S.C. 280g et seq.), as amended, is further amended  
17 by adding at the end the following section:

### 18 **“SEC. 399W. RESEARCH, EDUCATION, AND OTHER ACTIVI- 19 TIES REGARDING DIABETES IN MINORITY 20 POPULATIONS.**

21 **“(a) RESEARCH AND OTHER ACTIVITIES.—**

22 **“(1) IN GENERAL.—**In addition to activities  
23 under sections 317U and 434B, the Secretary shall  
24 conduct and support research and other activities  
25 with respect to diabetes within minority populations.

1           “(2) CERTAIN ACTIVITIES.—Activities under  
2       paragraph (1) regarding diabetes in minority popu-  
3       lations shall include the following:

4           “(A) Through the National Center on Mi-  
5       nority Health and Health Disparities, the Office  
6       of Minority Health under section 1707, the  
7       Health Resources and Services Administration,  
8       the Centers for Disease Control and Prevention,  
9       and the Indian Health Service, establishing  
10      partnerships within minority populations to  
11      conduct studies on cultural, familial, and social  
12      factors that may influence health promotion, di-  
13      abetes management, and prevention.

14          “(B) Through the Indian Health Service,  
15      in collaboration with other appropriate Federal  
16      agencies, coordinating the collection of data on  
17      ethnic and culturally appropriate diabetes treat-  
18      ment, care, prevention, and services by health  
19      care professionals to the American Indian popu-  
20      lation.

21          “(3) PROGRAMS RELATING TO CLINICAL RE-  
22      SEARCH.—

23          “(A) EDUCATION REGARDING CLINICAL  
24      TRIALS.—The Secretary shall carry out edu-  
25      cation and awareness programs designed to in-

1           crease participation of minority populations in  
2           clinical trials.

3           “(B) MINORITY RESEARCHERS.—The Sec-  
4           retary shall carry out mentorship programs for  
5           minority researchers who are conducting or in-  
6           tend to conduct research on diabetes in minor-  
7           ity populations.

8           “(C) SUPPLEMENTING CLINICAL RE-  
9           SEARCH REGARDING CHILDREN.—The Sec-  
10          retary shall make grants to supplement clinical  
11          research programs to assist such programs in  
12          obtaining the services of health professionals  
13          and other resources to provide specialized care  
14          for children with type 1 and type 2 diabetes.

15          “(4) ADDITIONAL PROGRAMS.—Activities under  
16          paragraph (1) regarding education on diabetes in  
17          minority populations shall include providing funds  
18          for new and existing diabetes-focused education  
19          grants and programs for present and future stu-  
20          dents and clinicians in the medical field from minor-  
21          ity populations, including for the following:

22                 “(A) For Federal and State loan repay-  
23                 ment programs for health profession students  
24                 within communities of color.



1           “(B) For the Office of Minority Health  
2           under section 1707 for training health profes-  
3           sion students to focus on diabetes within such  
4           populations.

5           “(C) For State and local entities to estab-  
6           lish diabetes awareness week or day every  
7           month in schools, nursing homes, and colleges  
8           through partnerships with the Office of Minor-  
9           ity Health under section 1707 and the Health  
10          Resources and Services Administration.

11          “(b) DEFINITION.—For purposes of this section, the  
12          term ‘minority population’ means a racial and ethnic mi-  
13          nority group as defined in section 1707.

14          “(c) AUTHORIZATION OF APPROPRIATIONS.—For the  
15          purpose of carrying out this section, there are authorized  
16          to be appropriated such sums as are necessary for fiscal  
17          year 2010 and each subsequent fiscal year.”.

○